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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

16–17

Sixteenth Day, Thursday, 24th April, 1958
Seventeenth Day, Friday, 25th April, 1958

WITNESSES

Royal College of Surgeons of England

Royal College of Obstetricians and Gynaecologists

LONDON
HER MAJESTY'S STATIONERY OFFICE
1958

FOUR SHILLINGS NET

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Witnesses

ROYAL COLLEGE OF SURGEONS OF ENGLAND

SIR JAMES PATERSON ROSS, K.C.V.O., P.R.C.S.
SIR HARRY PLATT, BT., F.R.C.S.
HAROLD EDWARDS, C.B.E., F.R.C.S.
SIR WILFRED FISH, C.B.E., F.D.S.R.C.S.
SIR WILLIAM KELSEY FRY, C.B.E., M.C., F.D.S.R.C.S.
PROFESSOR R. V. BRADLAW, C.B.E., F.D.S.R.C.S.

Pages 867—908
Questions 4054—4266

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

PROFESSOR A. M. CLAYE, M.D., F.R.C.S., P.R.C.O.G.
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J. H. PEEL, F.R.C.S., F.R.C.O.G.

Pages 909—936
Questions 4267—4437

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

SIXTEENTH DAY

Thursday, 24th April, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. J. H. GUNLAKE, C.B.E., F.I.A., F.S.S.
MR. I. D. MCINTOSH, M.A.
SIR DAVID HUGHES PARRY, Q.C.
PROFESSOR JOHN JEWKES, C.B.E.
SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C. (*Secretary*)
MR. J. B. HUME (*Assistant Secretary*)

EXPLANATORY NOTE BY THE ROYAL COMMISSION

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

(i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.

(ii) The quantity and quality of newly qualified doctors.

(iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.

(iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).

(v) The position and prospects of a newly qualified doctor.

(vi) Any trend to excessive resort to certain branches of the profession at the cost of others.

(vii) The relative advantages and disadvantages, financial and otherwise, of service as:—

(*a*) a principal in single-handed general practice,
(*b*) a partner in general practice,
(c) a whole-time consultant in the National Health Service,
(*d*) a part-time consultant with the maximum number of sessions,
(*e*) a part-time consultant with only a few sessions,
(*f*) a Senior Hospital Medical Officer,
(*g*) a doctor in any other sort of practice or employment.

(viii) The difficulties encountered by members of the registrar grades.

(ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.

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(x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.

(xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.

(xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.

(xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.

(xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.

(xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.

(xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.

(xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.

(xviii) Specific proposals for medical remuneration.

(xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.'

(xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.

(xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

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ROYAL COLLEGE OF SURGEONS OF ENGLAND

EVIDENCE SUBMITTED BY THE COUNCIL OF THE COLLEGE TO THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

PART A—MEDICINE

The Royal College of Surgeons of England

1. In 1800 the Company of Surgeons of London was reconstituted by Royal Charter as a Royal College of Surgeons. In 1843 the name was changed to The Royal College of Surgeons of England. The College is governed by a Council of twenty-four Fellows elected by postal ballot from the surgical Fellows of the College, of whom there are over 4,000 scattered throughout the world. In addition, representatives of various special branches of medicine and surgery also serve on the Council. There is within the College a Faculty of Dental Surgery and a Faculty of Anaesthetists.

2. The College is a scientific and educational body. Its activities fall into three main headings—(*a*) examinations ; (*b*) research ; and (*c*) postgraduate education.

Examinations

3. The College as a licensing body grants conjointly with the Royal College of Physicians of London the qualifying diplomas of L.R.C.P., M.R.C.S. Study for these diplomas must be taken at recognised medical schools and hospitals. In addition, the College also grants conjointly with the Royal College of Physicians diplomas in the following specialties: Anaesthetics, Child Health, Industrial Health, Laryngology and Otology, Medical Radio-Diagnosis, Medical Radiotherapy, Ophthalmology, Pathology, Physical Medicine, Psychological Medicine, Public Health, and Tropical Medicine and Hygiene. The College also grants the Licence in Dental Surgery. There are over 25,000 Members and Diplomates of the College.

4. The College grants three Fellowships (F.R.C.S., F.D.S.R.C.S. and F.F.A.R.C.S.) For each Fellowship candidates have to be in possession of a recognised medical or dental qualification before entering for a Primary Examination in the basic medical sciences. They must have completed appropriate recognised hospital appointments before sitting for the Final examination.

Research

5. Research is carried out in Surgery and allied subjects in the laboratories of the main Departments of the College, which are Anatomy, Physiology, Pathology, Pharmacology, Ophthalmology, Dental Science and Anaesthetics, and also at the Buckston Browne Farm at Downe, in Kent. Each Department has a Professor or Director in charge, together with appropriate staff.

Postgraduate Education

6. Postgraduate education in the basic medical sciences is carried out in the College in the Institute of Basic Medical Sciences which is controlled jointly by the College and the University of London. Teaching in surgery and in the major specialties is carried out in organised courses in the College itself, and by special arrangement in various hospitals in London. The courses vary in length between two weeks and two years. Over a thousand postgraduates are enrolled in the College every year.

Consultants and the National Health Service

7. When the consultants and specialists of the nation reluctantly agreed to enter the National Health Service, they did so on certain assurances. (1) That no attempt would be made to introduce a universal full-time hospital consultant service ; and (2) that the findings of the Spens Report (1948) would form the basis of all arrangements for future remuneration.

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8. As regards the first proviso, although in some Regional Boards minority groups have from time to time advocated an increase in the number of full-time appointments, the present day hospital staffing is based predominantly on the part-time system. This arrangement continues to command the allegiance of the vast majority of the consultants in this country, and the Royal College of Surgeons stands strongly behind this attitude for reasons which are set out later in this document.

9. The Spens Report envisaged the maintenance of the economic position of consultants and specialists in accordance with changing money values. The salary structure recommended in the Report represented an attempt to equate remuneration by salary with the net earnings in private practice as revealed in an analysis by a distinguished statistician of a significant sample of consultants' incomes in the year 1938–39. It was clearly stated that the salaries recommended in 1948 were based on the 1939 values of money. But it was not until 1954 (four years after the Danckwerts Award to general practitioners) that the first adjustment was made. In this *ex gratia* adjustment whereas the remuneration of junior officers in the hospital service was in some cases substantially augmented, some senior consultants with the highest distinction awards found that their remuneration had been ingeniously "abated". A further increase made on May 1st, 1957, showed that the hospital salaries of part-time consultants holding a 4, 5 or 6 sessional contract and receiving an A merit award, and those with a 5 or 6 sessional contract and a B award, were now less than the amounts in the corresponding grades previous to 1954! Such derisory increases clearly indicate a cynical disregard of the claims of the hospital consultants to a betterment award which should go some way at least towards closing the gap between the 1939 and 1957 purchasing power of the pound sterling.

Economic and Social Status of the Consultant

10. Although the Royal College of Surgeons is primarily concerned with the maintenance of the academic standards of surgery (both general and special) and of anaesthetics and dental surgery, it cannot ignore the fact that the material rewards open to surgical consultants profoundly influence both the quality of recruitment to the art of surgery and the way of life of the practising surgeon.

11. The education of the would-be surgeon is long, arduous, and expensive. After qualification a three-year period of postgraduate study and practical experience is demanded before the surgical aspirant is allowed to sit for the final F.R.C.S. examination, but in fact the average period is five years. Moreover, he cannot enter for the final until he has passed a primary examination in the basic medical sciences—a formidable hurdle to be negotiated. If successful in obtaining the F.R.C.S. diploma he will still need to undertake one or two further years of surgical training before he is likely to obtain one of the limited number of higher training posts in the rank of *senior registrar* at a teaching or non-teaching hospital. A minimum period of four years in these higher training posts is required before the young surgeon is considered fit to undertake independent responsibility as a consultant, and for some, the training may be prolonged beyond the four years by the valuable interpolation of a period of special experience in a surgical centre in the United States or Europe. The remuneration of the senior registrar in the first few years after the introduction of the Health Service may have appeared to provide a modest security, though with little or no margin for the essentials of a professional way of life. But in 1957 the augmented top salary, markedly devalued in purchasing power, now represents a retreat rather than advance.

12. Comparable austere circumstances confront younger surgical consultants in their earlier years. These are men who may have spent six years or even longer as senior registrars before being elected to the visiting staff of a hospital. Augmentation of the basic salary by private practice is often a slow process, and the catchment areas of many hospitals cannot for economic reasons provide a practice on any substantial scale.

13. The modern surgeon works under conditions of heavier physical and mental strain than his early 20th century predecessors. It was well said some thirty years

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ago by Sir John Bland-Sutton, a distinguished President of this College, that the prime need of a successful surgeon was "robust health". This is even more true to-day as major operations increase in length and complexity. But the surgeon is not a mere operating machine. The art of surgery looks more and more to the basic medical sciences for its subsistence, and if the surgeon is to keep abreast of advancing knowledge he needs "leisure" to read, to write, and to travel. These are traditional obligations to his art, and they are expensive. The surgeon must therefore be able to look forward to a standard of professional earnings which allows him to incur such expenditure without sacrificing essential family needs. If surgeons are so "squeezed" that these essential activities are no longer possible, then the quality and prestige of British surgery will decline. No civilised nation, least of all Great Britain, can afford to contemplate such happenings with equanimity.

14. Material considerations do not in the end determine the choice of a career in medicine, but members of a learned profession, so arduous in the demands made upon it, quite rightly expect to enjoy a relatively high economic status in society, and believe that the highest rewards should be open to men of outstanding ability as in the Law and other vocations.

Questionnaire

15. The College has selected from the questions submitted by the Royal Commission those on which it feels it can usefully comment.

Recruitment and Maintenance of Medical Students

16. For the past hundred years medical students have been drawn from a variety of social groups. There has always however been a nucleus in all medical schools of students from cultured homes—the children of parents rarely wealthy—e.g. the sons and daughters of doctors and of the vicarage and manse; or from comparable families whose children have been brought up to look upon medicine primarily as a vocation. The higher education of such children has often demanded a willing sacrifice on the part of the parents. Such sacrifices are still necessary to-day, as the gross professional income of the parent too often disqualifies the child for full scholarship grants. This ever-present nucleus has acted as a leaven and has been responsible for the continued high social prestige of the profession as a whole, and above all for the maintenance of medicine as one of the learned professions in the community. Medicine would lose immeasurably if the proportion of such students in the future were to be reduced in favour of precocious children who qualify for subsidies from Local Authorities and the State purely on examination results.

Whole-Time or Part-Time Consultant Appointments

17. Although for economic or other reasons there may be a place for a limited number of whole-time non-academic consultant posts, most consultant posts should be part-time. An exclusive contractual dependence on central government or any of its agencies is not a desirable relationship for members of a self-governing learned profession for whom a substantial measure of independence is vital. This type of freedom means the opportunity and the right to deal with patients as individuals in their own homes and not solely with groups of patients assembled only under institutional conditions. A part-time contract with the maximum number of sessions is the most desirable arrangement for consultants on the staff of the great majority of non-teaching hospitals, and is essential in the smaller centres where private practice is scanty. Furthermore, an appointment of this type means that consultants tend to live near their hospitals, and thus have an opportunity to share in the civic and cultural life of the town or city in which the hospitals lie. A maximum part-time appointment can also provide, both clinically and scientifically, a satisfying career for any consultant who, by reason of the range of experience so offered, feels the urge to take part in clinical investigations, thus adding his contribution to knowledge, and so fulfilling his indebtedness to his art. A part-time contract with only a few sessions is an appropriate arrangement where it is desired to retain the services of a senior consultant. It is an uneconomic arrangement for a young consultant and is therefore not to be regarded as an acceptable basic pattern for hospital staffing.

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Registrars

18. Immediately after the war many supernumerary "registrar" appointments were created whose holders were encouraged to undergo prolonged training for a hypothetical number of consultant appointments to be provided by the forthcoming National Health Service. A proportion of these pre-N.H.S. Act registrars have reached the position of highly trained senior registrars of more than four years' standing without as yet having a consultant appointment in sight. There is a moral obligation to ensure their future.

19. The title "registrar" is misleading in that it continues to be applied indiscriminately to senior resident posts essential (as they were in the past) to the efficient day-to-day working of the hospitals, but not all stepping-stones to the limited number of *senior registrar* appointments now regarded as the only true training posts for future consultant status. We are of the opinion that the present-day title of registrar should be abolished and for these men and women the well-established titles of Senior House Surgeon, Resident Surgical Officer, Resident Medical Officer, and so on should be restored. This would make it clear that these men and women are not yet chosen as trainees for consultant posts. The term Registrar should therefore apply in the future only to present-day *senior registrars.*

20. The opportunities for the absorption into practice—both general and specialist—of well-trained registrars and of a proportion of senior registrars, have become severely restricted in the past few years both at home and abroad. The present attitude of general practitioners is to regard a young doctor well trained in surgery as unsuitable to join a partnership. A change of attitude is most desirable. No longer are there careers in the Indian Medical Service, and very few in the Colonial Medical Service.

21. The virtual extinction of the general practitioner-surgeon class has closed yet another avenue. This we regard as a retrograde step, for at many hospitals there is room within surgical teams headed by a consultant for the competent general practitioner-surgeon.

Private Consulting Practice as an Incentive to Entering the Consultant Branch of Medicine

22. The sense of independence engendered by freedom to engage in private practice reflects one of the most cherished traditions of the profession—the doctor-patient relationship. Furthermore, private consulting practice brings a consultant in personal contact with a wider range of social groups in the community. He meets men and women important in public life, in business and the professions, without the embarrassment of a pre-arranged "national" contract. He is free to offer them his skill at times and places suitable to all concerned. Private practice augments a consultant's professional income and is thus one of the important incentives appropriate by long tradition for the free and learned professions. The importance of "differential" rewards was fully realised by the Spens Committee and it was to meet this essential demand that the Distinction Award system was devised. In addition to the incentive to the individual, there is the undoubted value of private consulting practice to the nation, both as regards prestige and the augmentation of the national income by patients from abroad who may wish to come to this country for private treatment.

Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service

23. The present situation as regards the whole-time consultant is inequitable, and should be remedied without delay. It cannot be emphasised too often that the *professional clinical* obligations of the part-time consultant and the whole-time consultant are identical. They are based on a responsibility for patients 24 hours in the day, seven days a week, and 365 days a year, a responsibility interrupted only during periods of leave in which the care of the patient is delegated to a colleague of equal status. For both the part-time and whole-time consultant this continuous obligation

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involves the same need for heing on emergency call, and therefore the same need for the possession of a telephone; the use of a car; the obligation to attend meetings at home and ahroad; the same liahility for expenses incurred in the preparation of lectures, articles for the medical press and text-hooks—and so on. For the part-time consultant, these are overhead expenses and non-taxahle. It is not widely known that the whole-time consultant does not receive their equivalent as direct tax-free allowances from his employing authority.

Distinction Award System

24. As far as we are ahle to judge, the Distinction Award system seems to have worked well and so far has given rise to very little criticism. As we have already said, there must he differentials in rewards in all free professions. Consideration might well he given to extend the system to emhrace those engaged in general practice.

Specific Proposals for Medical Remuneration

25. The College has already in an earlier part of this document expressed the view that the existing scales of consultants' remuneration should he reviewed as envisaged in the Spens Report, in order that they should represent equitahly the present-day values of money.

Whitley Council

26. We consider that the Whitley Council System, admirable no douht for a wide range of manual and clerical occupations, is not the proper mechanism for discussions hetween a free and learned profession and the so-called "employing authorities". It should not he impossible to devise an Arhitration Council of the highest level which would be acceptable to the medical profession.

PART B—DENTAL SURGERY

Preamble

27. The Royal College of Surgeons of England has heen actively and continuously concerned with dental education and with the professional examinations taken hy dental students for nearly one hundred years. In fact, the College was the first statutory hody in the United Kingdom to introduce examinations for a registrahle dental qualification. These examinations have heen held uninterruptedly since 1860 and more dentists in the United Kingdom have obtained the Licence in Dental Surgery of this College than have taken any other dental diploma or degree. In the years 1950–54 inclusive 1,106 of the 2,736 dentists whose names were added to the Register held this Licence. This extensive connection with the science and the practice of dental surgery was made even closer hy the creation of the Faculty of Dental Surgery and the institution of a Fellowship in Dental Surgery hy the Council of the College under Royal Charter in 1947.

28. The Fellowship in Dental Surgery is recognised as a higher qualification which most consultants in dentistry in England and Wales would he expected to hold.

29. The Faculty of Dental Surgery was founded to advance the science and art of dental surgery, to encourage study and research, and to protect the rights of dental surgeons acquired by them as Fellows or Licentiates in Dental Surgery of the College. It is governed under the Council by a Board elected hy the Fellows and Licentiates and a Dean elected by the Board.

30. Its principal activities are concerned with:—

(*a*) the Licensing and Fellowship Examinations and the examinations for the Diploma in Orthodontics,

(*b*) courses of instruction in connection with the Fellowship in Dental Surgery and other diplomas of the College,

(*c*) special lectures hy eminent persons from the United Kingdom, Dominions and ahroad,

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(*d*) inspection of hospital departments in relation to their suitability for post-graduate training,

(*e*) representation upon statutory committees for consultant and other appointments in the hospital dental service,

(*f*) promotion of research through its Department of Dental Science, and

(*g*) advising the Council of the College upon all matters connected with dental surgery.

31. The Royal College of Surgeons of England is therefore a body which is fitted by experience to offer evidence to this Royal Commission on dental surgery at hospital and consultant level. Moreover, its position as the licensing body for a high proportion of the dentists in general practice leads it also to extend its concern to the conditions in which these licentiates work. The causes of dissatisfaction among them were studied in detail by the Committee on Recruitment to the Dental Profession and are subject of comment in the Report of that Committee (Paragraphs 61–74) and indeed of recommendations for a thorough review of the whole system of remuneration. The striking decline in dentists' earnings during the latter part of their careers, a circumstance which apparently obtains in no other profession, the virtual disappearance of the goodwill value of practices, and apprehension that financial returns may be abruptly diminished by sudden alterations in the regulations, these are circumstances which the College views with no less concern than did the Inter-Departmental Committee. The presentation of further evidence on these aspects will, however, come more fittingly from other professional organisations.

32. The following paragraphs, in which the number corresponds to the list of questions supplied by the Royal Commission, contain information arising out of the experience of the College in its educational activities and through its connection with hospital and consultant practice.

(ii) *The quality and quantity of newly qualified dentists*

33. When the Dentists Act of 1921 was passed there were only some five thousand Dental Surgeons in the United Kingdom and many of these were medical men with dental qualifications. From the days of John Hunter (1728–93), who incidentally practised dentistry himself, dental surgeons had regarded themselves as practising a branch of surgery and as being required to conform to the same code of professional ethics as general surgeons. There was also a strong family tradition so that recruits were often drawn from professional homes where learning and culture were honoured for their own sake. In the circumstances that obtain today, however, professional men whose incomes are just above the arbitrary level for Local Education Authority Grants often find it impossible to give a professional education to two or three children, and dentistry is the poorer by the subtraction of an element which proved so important in its historical development and which we should expect to have played a leading part in its further establishment as a free, liberal and learned profession.

34. The quality, in so far as this refers to the professional competence of the new entry, however, is safeguarded by the standard of the examinations which are required to be passed by candidates for the Licence in Dental Surgery of this College. Moreover, since the war—except for 1952 and 1953—the number of applications for places in the Dental Schools has been greater and there has therefore been an opportunity for the schools to be more selective. The academic standard of those entering the profession is thus maintained, though for the reasons we state above we could wish to have more sons and daughters of professional men; and indeed it would seem to be a very serious criticism of the conditions under which Dental Surgeons practise today that they should often be unable to afford to put their sons and daughters into their own profession. We do not believe that the Royal Commission will allow this unhappy state of affairs to escape their notice.

35. The quantity is a matter of greater concern.

36. Although there have been more applicants since the war there was a dangerous fall in 1952 and 1953 which led to the Committee on Recruitment to the Dental

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Profession being set up. The warning in the Report of that Committee that the number of practitioners is about to diminish, whatever steps be taken to increase recruitment, is viewed by this College with the gravest concern and we would urge with all the emphasis at our command that the remedies proposed by that Committee be adopted without further delay. These include the building of more schools and the training of more teachers as well as securing a greater degree of contentment amongst members of the profession themselves who must always be the best advocates in attracting new recruits.

37. The dental profession makes a contribution to the comfort and efficiency of the community that is both important to its welfare and highly prized by the individual though dental services are no doubt taken very much for granted so long as they remain available. It would now appear that it is already too late to avert a shortage that may well amount to a national crisis of no small significance. It is therefore a matter of great urgency to apply the remedies prescribed. The one with which the Royal Commission is particularly concerned is that the profession should be relieved of financial anxiety and that the sense of injustice under which they labour should be removed. This can only be effected by establishing their remuneration on a scale to give them an assured social position appropriate to the responsibilities they shoulder, to the length of their training, to their arduous daily task and to the importance of the service they render to the community.

38. This is not only a matter of justice but is an essential corollary to the building of new schools if the entry is to be raised and maintained at the level recommended in the reports of both the Committee on Recruitment to the Dental Profession (1956) and the Inter-Departmental Committee on Dentistry (1946), a level which is minimal if the most serious results of the impending shortage are to be averted.

(iv) *The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the individual grants and the proportion of students receiving them)*

39. While the length of the degree course for dentistry is in some Universities the same as that for medicine, in general the courses are somewhat shorter. Nevertheless, the cost of the training is greater. This is due in some cases to higher annual tuition fees for dental students; and in any case, books, dental instruments for use in the clinical years, anatomical specimens, mechanical tools (all of which the student is required to provide himself) together with hire of microscope cost over £200.

40. These circumstances accentuate the difficulty that professional men experience in sending even one child to the University for five years if their incomes are just above the level applied by the Local Education Authorities in awarding their grants. If they have more than one child to consider the difficulties may be insurmountable.

(vi) *The relative advantages and disadvantages, financial and otherwise of service as:—*

(*d*) a whole-time consultant,

(*e*) a part-time consultant with the maximum number of sessions,

(*f*) a part-time consultant with only a few sessions,

(*g*) a Senior Hospital Dental Officer,

(*h*) a General Dental Surgeon in the hospital service,

(*j*) a dentist in any other sort of practice or employment.

General Comment on Hospital Staffing Problems

41. The number of Dental Consultant appointments, either full-time or part-time, is quite insufficient for the needs of the Hospital Service. Moreover, those who have conscientiously undergone the long course of training as Registrars, and who are worthy of consultant status, find that few posts are available to them. This inevitably leads to frustration and widespread dissatisfaction so that it has become

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a matter of extreme difficulty to encourage enterprising young men of merit to train as consultants. Recruits to this branch of the Profession have been lost and will continue to be lost as long as this feeling prevails.

42. Whatever may be the reason, Boards of Governors of Teaching Hospitals and Regional Hospital Boards have not met the basic requirements of the recommendations relating to the dental service in hospitals and it would appear that the only solution is a separate central grant to promote the hospital dental service.*

43. The provision for dental treatment in general hospitals is correspondingly unsatisfactory; in many either there is no dental department or else it is inadequate in respect of accommodation, facilities and staff. Consultants may have to carry out work which is within the capacity of a general dental practitioner and which the general practitioner could do more economically. Where there is no consultant, or where adequate facilities are lacking, registrars cannot of course be trained.

(vi) (*d*) *a whole-time consultant*

(vi) (*e*) *a part-time consultant with the maximum number of sessions*

44. In whatever category he may serve, the full-time Officer is at some disadvantage in comparison with his part-time colleague in respect of allowances for taxation. Nevertheless, since private consulting practice is meagre in dentistry in comparison with that in medicine and surgery, it would seem that a large proportion of full-time or almost full-time posts is most appropriate. We regard this as a regrettable necessity and we endorse the views expressed in Part A as to the need for a special measure of independence to which a professional man is entitled and which is essential to those who have the responsibilities of leadership.

(vi) (*f*) *a part-time consultant with only a few sessions*

45. This is the usual type of consultant appointment now available particularly in teaching hospitals. It is a continuation of the system of honorary appointments which existed before the inception of the National Health Service. The dental consultant attended on a small number of sessions per week without remuneration, and these posts were only held by those who were sufficiently interested in hospital and teaching work to do it without payment; they formed the backbone of the voluntary hospital system.

46. In teaching hospitals there is a strong case for the continuance of part-time appointments but each should involve attendance on a minimum of 3-4 sessions per week. The holders of these posts in addition to carrying out clinical work play a most important part in undergraduate instruction.

47. At present, however, a number who attend only for one or two sessions weekly have twenty-five years to serve and it would therefore be necessary either to increase the number of consultant sessions or to wait until consultants retire and give their sessions to their colleagues. The latter procedure would block the young entry to consultant rank for a long time, and we strongly urge that in those teaching hospitals where this system finds its fullest expression the number of consultant sessions be increased.

48. Apart from the teaching hospitals, we believe that, elsewhere in the Health Service, dental consultants should be employed for one or two sessions per week only in exceptional circumstances, and the comments in Part A are endorsed. Such a system does not promote efficiency or economy in the working of the hospital service.

(vi) (*g*) *a Senior Hospital Dental Officer*

49. Appointment as a Senior Hospital Dental Officer was intended for those whose duties included clinical teaching or work beyond the scope of a General Hospital Dental Practitioner. It was not intended that dental surgeons in these grades should

* Section XI. Sub-section 92 Ministry of Health Publication (1950) "The Development of Consultant Services"—*Annexure*.

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take the place of consultants and we deplore that some appointments of this kind have been made where the posts carry the responsibilities and require the experience of a consultant.

(vi) (*h*) *a General Dental Surgeon in the Hospital Service*

50. Attention must be drawn to the disparity in sessional pay between General Medical Practitioners (at the rate of £175 plus the recent addition awarded by Parliament) and General Dental Practitioners (at the rate of £150 plus the recent addition awarded hy Parliament).

51. There seems no justification for this, particularly as a General Dental Practitioner's practice expenses are much heavier than those of a General Medical Practitioner and continue when he is away from his surgery.

(vi) (*j*) *a dentist in any other sort of practice or employment*

52. *Research Appointments:* The College has long shown an interest in dental research which culminated in the creation of a Department of Dental Science within the College in 1955. The position of the whole-time dental research worker is considerably less advantageous financially than that of tbe general dental practitioner. He requires much longer training during which time he is not earning and then obtains remuneration which is much less. He has doubtful security of tenure and doubtful prospects of advancement. Facilities for work are often poor and there are few alternative posts to which he can change if dissatisfied. He does not receive tax concessions to which a dental surgeon in general dental practice is entitled.

53. *Teaching appointments:* Junior dental teaching posts are increasing in number, but do not attract a satisfactory field of applicants owing to the small salary which attaches to them. The junior whole-time dental teacher suffers financial disadvantage compared with the general practitioner of the same age as regards scale of salary and liability to taxation. Tbis disparity is most marked at the beginning of a teaching career but an even more serious factor in dissuading able young men from embarking on one is tbat there are too few senior posts to whioh they may aspire.

54. If any expansion of the scbools is to take place the recruitment of junior staff will present greater difficulties than anything else.

(vii) *Any special difficulties encountered by the Registrar grades*

55. As we have said there is much dissatisfaction amongst holders of this type of appointment, due to the dearth of senior posts in the Regional Board hospitals and also in the teaching hospitals.

56. *Senior Registrars:* These are men who hold a higher dental qualification and not infrequently a medical qualifioation also. In the case of the senior registrar with higher dental qualifications only, it is necessary for him to spend 2 years as a registrar and 3–4 years as a senior registrar. Taking into account his bouse surgeon appointments, this means that a man cannot consider his training complete until 11 years after commencement as an undergraduate student. A man bolding a medical qualification may take longer still. The dental surgeon is then between 28 and 33 years of age. Having been encouraged to embark on a full-time training, on the assumption that there will be an appropriate number of full-time senior posts available in the future, most senior registrars find on completion of their training that there are no consultant posts available owing principally to the failure of the majority of the Regional Boards to develop the dental service in tbeir hospitals. It is true that a man who has had a registrar's training of seven years could find a place in private dental practice but it would be a bitter disappointment and he would have been subjected to severe financial stringency during his training without commensurate gain.

57. As a result of this situation applications for consultant training from young dental surgeons of the right calibre have virtually ceased, and in our opinion, it is an urgent requirement that there should be a sufficient number of full-time consultant posts established in order that there may be an uninterrupted rise from

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registrar to consultant status for those who have submitted to the arduous training involved and are worthy of promotion.

58. Excluding honorary appointments, in England, Wales and Scotland there are 293 dental consultants (including those in teaching hospitals) and this would at first seem to be a reasonable number in proportion to the total number of dental surgeons in these countries. However, on investigation it is found that many of them are part-time consultants and are doing only from 1–3 sessions a week. Estimated on a full-time basis, therefore, the total number of dental consultants in England, Wales and Scotland cannot possibly be in excess of 90, and even this figure gives an unduly favourable impression since most of these consultants are concentrated in the teaching hospitals leaving very few for the hospitals of the Regional Boards.

59. We have referred to the discouraging effect of these factors on the recruitment of applicants for consultant training. In contrast, in the specialty of orthodontics where a number of consultant posts have recently been created, applicants for specialist training are now coming forward in satisfactory numbers.

60. *Registrars:* Again, these are training posts, mainly full-time, but part-time in some teaching hospitals. There is the danger that the holders of such posts in general hospitals may receive inadequate training owing to the shortage of consultants in the Regions. This is a most regrettable state of affairs, and quite contrary to that envisaged when this type of post was created.

(xi) *General comments on the system of distinction awards for consultants and the method of allotting them, with any suggestions for an alternative system*

61. As far as it is possible to judge, the system of Distinction Awards is working equitably and smoothly. We know of no method less likely to cause disharmony.

(xvii) *Proposals for specific machinery or procedures to be established for dealing with future discussions of dental remuneration*

62. We consider that it is essential to the healthy development of a dental consultant service that dental and medical consultants' remuneration should be equal. We believe that this has been a most valuable factor in implementing the dental consultant service from the beginning and has encouraged a high standard of attainment based on an equally long training for dental consultants.

63. We consider that whatever machinery be adopted for medical consultants should also be used in settling disagreements that may arise in connection with dental consultants' remuneration.

Annexure

Ministry of Health publication on

THE DEVELOPMENT OF CONSULTANT SERVICES (pub. 1950)

SECTION XI, Sub-section 92

It is advisable that a dental surgeon specialising in oral surgery should be available in a large centre or for a group of smaller centres. One such consultant, working whole-time, would probably meet the needs of a population of about 300,000; he might supervise generally the work of any resident dental staff, some of whom should be consultants in training.

JAMES PATERSON ROSS,
President.

Lincoln's Inn Fields,
W.C.2.

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Examination of Witnesses

SIR JAMES PATERSON ROSS—*President*
SIR HARRY PLATT
MR. HAROLD EDWARDS
SIR WILFRED FISH
SIR WILLIAM KELSEY FRY
PROFESSOR R. V. BRADLAW

on behalf of the Royal College of Surgeons of England
Called and Examined

4054. *Chairman*: Sir James, we have had your memorandum, and we have considered it carefully. We asked you to come a little bit earlier this morning than we have been asking most of the bodies because we thought we would probably be able to get through this before lunch without pressing you unduly. I do not want to restrict you in anything you may want to put either on these or other points which may have occurred since you first got our questionnaire on which you have given us these answers; but you may know that we were in Scotland a few weeks ago when we saw the three Colleges up there, including the Royal College of Surgeons of Edinburgh. In the course of our visit we asked some 600 questions, so that we have covered some of the topics in which we are particularly interested fairly thoroughly. We may not therefore need to go into all those so thoroughly with you. You probably realise, and I do not need to say, that it is our job to test all the submissions made to us by thorough questioning, and that if we do not nobody else is there to do so. We would hate it to be thought by any witness, either those present or those who have appeared before us already, that we have made up our minds on any of these particular matters about which we are questioning. Our questions are not intended to show that. You will also know that we have already sent out to doctors a questionnaire on actual earnings and it has already been answered by a very high proportion of them. A similar questionnaire has also gone out to members of some other professions and will go to a good many others, but until we get those facts we cannot possibly deal with the second part of our terms of reference, which is broadly to recommend actual levels of remuneration in the light of the current earnings situation. I wished to make just those few preliminary remarks.

Therefore you will appreciate that any questioning that we may go in for does not imply disbelief in any points you have submitted, or scepticism. Equally whenever we miss a point you have made in your written evidence it does not mean that we have accepted any proposition put forward by you.

We have distributed the work of this Commission mainly to two sub-committees. I do not think it is because someone of your name is President at the moment that we have distributed this one to the Northern sub-committee under Sir Hugh Watson, but I think you will probably be able to talk in very similar idioms if you feel so inclined. Sir Hugh has been Chairman of the sub-committee which has considered your evidence, and I would like him to take over.

First of all I see that you are represented by six people, and I believe one of you can speak particularly for the dentists, is that so?——*Sir James Paterson Ross*: Sir Wilfred Fish, Sir.

4055. To the extent that there are any special points affecting the dental profession rather than the medical one, Sir Wilfred will be able to answer?——I would like to make it clear that there are actually three representatives of the dental profession here, Sir Wilfred Fish and Sir William Kelsey Fry, and also Professor Bradlaw; so that actually there are three who can answer questions for them.

4056. *Sir Hugh Watson*: Sir James, in your memorandum which you have given to us you do outline in the opening paragraphs the functions and the status of the Royal College. Perhaps we do not need to go into that in detail,

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beyond just saying for the record that the College is a scientific and educational body?——Yes, Sir.

4057. And as you mention in your paragraph 2 its activities fall into the three main headings of examinations, research and postgraduate education. As you bring out later, the Fellowship of the Royal College is granted after some very stringent discipline and very stringent examinations, and it is in fact a highly prized distinction?——That is right.

4058. May I take it then, Sir James, that the majority of your Members, and of those whom you represent here before the Commission today, probably come within the consultant branch of the profession?——Yes, as far as the Fellows are concerned. A certain number of the Members also might be consultants, but I think, Sir, we may say that the body that we are speaking for principally are the Fellows of the College.

4059. And therefore in your memorandum on the medical side you do not to any extent deal with the problems confronting the general practitioner?——That is right, Sir. We have had them at the back of our minds because of our Members, but we have rather left that subject to others who are giving evidence to the Commission.

4060. Now, Sir James, in your memorandum, when you come on to deal with the problems which confront the Commission, the questions on remuneration, you go back to that basis with which we are all now so familiar, the report of the Spens Committee on consultants on which the consultants agreed to enter the Health Service. We have had, as you will appreciate, many opportunities of enquiring into these Spens Reports, and this one in particular. Could you tell us, generally speaking, whether the view of the Royal College is that Spens was a base on which you expected to rest for all time?——May I say one thing before that question is answered? We rather hope that you will permit us to divide the answering in giving evidence to the Commission into sections. I would be prepared to speak about the general activities of the College, and Sir Harry Platt, who has been familiar with Spens from the beginning, might, if you would permit it, answer you especially about these matters which you are asking me now.

4061. Certainly.——Is that allowed?

4062. *Chairman*: That is absolutely right. You will be asked questions by many people, and we would like you to allocate the answers to whoever is best qualified to speak.——If I might ask Sir Harry to reply to that?—*Sir Harry Platt*: I think that the first question is in a way far too sweeping. I was a member of the Spens Committee, so I am very familiar with not only its findings but the spirit and the intent behind it. What I would really like to emphasise is that the crux of the whole situation is this: the scale of remuneration the Spens Committee agreed upon as the starting point and based on 1939 values bore no relation to any of the full-time services then existing—medical officers of the Armed Forces, in Government employ, in Universities, scientific institutions, and so on. It was, as we say in our memorandum, and this is most important, a conclusion based on the equation of a hypothetical salary range with the earnings from private practice. The 4,000 odd consultants then existing—there are now 6,000—had never in their history considered that their remuneration—as with the Bar, which is the only other comparable profession today—bore any relation to existing full-time services. That is fundamental. That is the case, as it were, for the defence, that the 4,000 consultants, or 6,000 there are now, represent a body quite apart who were recruited through a totally different set of circumstances, with the highest diplomas which were not necessary in all these other services, with a long period of academic and practical training; a body which no other branch of the medical profession or any full-time medical officers in Whitehall really compared with. I would like to emphasise that.

4063. I accept that, but, of course, as you know far better than we do, before the National Health Service there were, broadly speaking—there may be many more—but there were broadly speaking two types of consultant, were there not? In the first place there were consultants in the local authority hospitals whom you probably would not regard as consultants in the sense in which you were speaking just now?——At that time very few of those occupied in the eyes of the profession, as it were, the higher brackets. It was not a question of remuneration, but of leadership and

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status. It was an artificial situation created by one or two local authorities.

4064. And these gentlemen were all paid by way of salary?——Yes.

4065. On the other hand you had the branch of the profession which you really represent here today remunerated almost entirely by way of fees?——Yes, and very often with small part-time salaries either at voluntary hospitals or local authority hospitals.

4066. And in the voluntary hospitals, gentlemen who afterwards rose to the highest positions in your profession began, as you say, with a token payment and were glad to be allowed into these voluntary hospitals in order to learn their profession?——In order to practise their profession. They were not appointed to the staffs of these voluntary hospitals until they had acquired after the highest academic attainments and practical experience a degree of skill which the governing bodies of those hospitals demanded when making their selection.

4067. Before they got to that point they were in the hospitals in some capacity or another as assistants?——Yes.

4068. And they were learning their profession?——Yes, below the consultants.

4069. They were earning very little?——Very little indeed.

4070. And Spens went a long way to rectify that, did he not?——Absolutely.

4071. One of the things that the Spens Consultant Committee did was to put the embryo consultant on a much more sure financial footing in his early days than he was before.——Quite so.

4072. In paragraph 9 of your memorandum you say, Sir Harry, that it was not until 1954 that the first adjustment on the Spens recommendation was made. That is not quite so, is it?——These I think are quotations. I think my President would agree that the Royal College of Surgeons is really not concerned with half crowns, as it were. We have paid very little attention to details of remuneration. We have dealt with the broad issues in terms of the status of the consultant and with equity in the background.

4073. I quite accept that, and if you please we will not talk about half crowns. But may I ask you to look please at the first sentence of your paragraph 9 where you say:—

> "The Spens Report envisaged the maintenance of the economic position of consultants and specialists in accordance with changing money values."

Spens directed that those who were to do the part of the task which he did not feel competent to carry out were to have regard to two things, did he not? To have direct regard not only to the value of money, but also to the increases which have in fact taken place in incomes, both in the medical and in other professions.——Yes.

4074. So would you agree that in endeavouring to carry out the remit with which it is entrusted this Royal Commission would be doing justice to the situation if it had direct regard to both these factors as they find them today?——Yes, Sir, provided the basic meaning of the original Spens scale of remuneration and salary scales is recognised. If I may I would quote from "The Times" the evidence from the Health Departments, and I would regard the sweeping conclusion there as quite invalid and based on the concept that doctors under the National Health Service represent a homogeneous 30,000 or 40,000, whatever it is. . . .

4075. *Chairman*: I did not catch the reference, Sir Harry. I am not quite sure what you are referring to.——I quote here: "An increase in the pay of National Health Service doctors will not only directly affect the pay of doctors in these spheres"—the spheres mentioned above, doctors in the Civil Service, the Armed Forces, local government, Universities—"but is likely to have widespread indirect repercussions throughout the salaried classes in Government and public service." I challenge that.

4076. *Professor Jewkes*: Is this from the London "Times"?—*Sir Hugh Watson*: Is it a report of the proceedings of this Royal Commission last week?——I may be out of order, but it is very germane to the thesis which the Royal College of Surgeons is maintaining in representing, as Sir James has said, the Fellows of the College who are a substantial number of the 5,000 or 6,000 consultants in the United Kingdom.

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4077. *Professor Jewkes*: Could we have the date of "The Times" report. It would be useful?——I have taken the cutting without dating it. It is a few days ago.

4078. Was it in connection with the publication of the Willink Report, or anything of that kind?——It is a report of evidence given to the Royal Commission here.

4079. *Sir Hugh Watson*: Last week. It is in fact, Sir Harry, a summary of a portion of the memorandum put in by the Ministry of Health.——I would submit, of course, it is a remarkable bit of innocent or deliberate special pleading.

4080. It is undoubtedly an extract from the Health Departments' memorandum. The words are very familiar.—— We challenge the very basis of this idea that the yardstick of the remuneration of the consultant, whether it is in fees, or from a system of National Health Insurance, or voluntary insurance, bears any relation to the whole-time services which have existed for generations.

4081. Could I put this question to you? Some of your colleagues are professors in Universities, and some of your colleagues are clinical professors in Universities?——Yes.

4082. Those of your colleagues who are clinical professors have the opportunity of attaining to, and no doubt many of them do attain to, the distinction awards. You must be aware that the remuneration which medical professors, clinical and otherwise, enjoy has in due course repercussions on the remuneration of other professors not only in the medical but in other faculties in the Universities?——Yes. That atmosphere of envy, shall I put it, did not exist before the war, before the Act. It was recognised that the way of life of the clinical consultant who dealt with the sick man was totally different from the way of life of someone who had entered another walk of life enjoying the remuneration, the pension, the conditions of work, and so on, of another sphere. I know there has been agitation in the Universities. I know in my own University—when this came in, I was still an active member of the Senate—that this atmosphere as it were of criticism or envy was fanned to some extent. But that is unfortunate, and it does not alter the fundamental situation that the way of life, the arduous and continuous twenty-four hour responsibility of the man who deals with the sick patient as an individual, is a way of life which is unique, and which has no comparison in the full-time services, in the Armed Services, Whitehall, the Universities, and so on.

4083. That aspect of the matter has been pressed upon us, and rightly pressed upon us, but the fact remains that before the National Health Service you and your colleagues, if you were professors in the Universities, obtained a salary from the University, but you also derived fees from your practice outside about which the University knew nothing?——It was not their business.

4084. Nothing to do with them at all?——No.

4085. But now the position is quite different; it is known what the remuneration of clinical professors is, and it has repercussions. I would rather substitute a more colloquial word, if you do not mind, for your word "envy". Is it not part of the general game of leapfrogging which goes on today?—— I quite agree with you. It is really one of the deteriorations in our society that this sort of thing is happening.

4086. Can we come back to what the Ministry of Health said last week? It does not seem to me at all unreasonable —the Commission have not had a chance of considering this among themselves—it does not seem to me at all unreasonable to suggest that the level of remuneration of consultants who now, whether they think it is a good thing or not, are to some extent at least remunerated on a salary basis, must have repercussions upon the remuneration of other medical people, and in due course on other persons in the employment of the Crown?——I think the fire has been lit, I quite agree, and those repercussions will go on now. It is a pity, but I quite agree it is a human situation.

4087. Having arrived between us at that point, may I say that this point was put up by the Ministry of Health last week as I understood it simply as a red flag, more or less by way of saying to the Commission: "You will have to be very careful what you do here, because if you do this thing in a big way it will

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have effects." That is a matter which the Royal Commission will have to weigh up and decide what effect to give to it. But you see now what is meant by that quotation which you read?—— I hope whoever gave that evidence had facts to support it.

4088. It was given by the senior civil servant in the Ministry of Health.—— That was his personal opinion.

Sir Hugh Watson: No. I think it is fair to say that it was the considered opinion of his Department. It was their experience.

4089. *Chairman*: Sir Harry. I would like to go back a little bit further. Sir Hugh drew attention to the point in your memorandum where you seem to refer only to one of the two criteria mentioned by Spens. He said direct regard should be paid not only to changes in the value of money but to increases which had in fact taken place since 1939 in incomes both in the medical and in other professions. I was not sure whether you were challenging that conception or not?——No, Sir, in actual fact the evidence before the Spens Committee from other professions, as far as I remember, was not forthcoming.

4090. No.——It was unobtainable.

4091. Spens said, "we leave to others" the decision as to what the rate should be in 1948, or whatever year it was, but it should have regard to these two factors, and you have only named one here in your submission to us.——Yes.

4092. Does that mean that you think the second one named by Spens ought not to have been taken into account?—— No, I think it represents part of a wide remit, and that part of it in practice really faded into the background. I think behind it, too, in the eyes at any rate of the medical members, was that it was a protection against any attempt to reduce the consultant's earnings by this revolutionary change into a salary system.

4093. *Sir Hugh Watson*: I quite accept the point that you made that not a great deal of information was available to the Spens Committee about the remuneration in other professions. The point that I think the Chairman has just taken up is that when they considered the whole matter, Spens—you and your colleagues on the Spens Committee—fixed what in their opinion would be appropriate remuneration for consultants at 1939 values, and then they went in for this classic phrase with which we are so familiar: "We leave to others the problem of the necessary adjustments to present day values . . .". That was in 1946, and you remember Spens never went a day further than 1946—"We leave to others the problem of the necessary adjustments to present day values of money, but we desire to emphasise as strongly as possible that such adjustments should have direct regard not only to estimates of the change in the value of money, but to the increases which have in fact taken place since 1939 in incomes both in the medical and in other professions."——I agree that is quite impeccable.

4094. What the Spens Committee had in view at that time was that in any discussions which were to ensue in the future, and the Government have always said that their view of Spens was that the remuneration of the medical profession should be discussed with the profession—in your case in Whitley B—on the basis of these two factors, due regard being paid to both of them. As you are aware, there was not available to Spens a great deal of information about the incomes of other professions. But as the Chairman began by saying, this Commission is sending out questionnaires to I think it is 17 other professions, and we would hope to get from that fairly full information about the spread of incomes in those professions in recent years. Would you agree that that ought to give a reasonable basis of comparison?——It would be, of course, a basis of argument or discussion on equitable increases, but again I come back to this point that even the earnings in accountancy, engineering, and so on, bear no relation really to the earnings of consultants in this country. Whether there is a percentage increase on present day values, and so on, which has some reference to the financial picture which other professions give is immaterial, so to speak, from the point of view of the Royal College of Surgeons. That must be left obviously to negotiation and discussion, but we do represent a wing of the profession which in a free profession has set its own standards of remuneration.

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4095. *Professor Jewkes*: When Professor Bradford Hill was making a census of pre-war earnings for the purpose of your Committee, he had to find his own definition of consultant as there was no standard definition of consultant. He did that, and he found 1,700 consultants who conformed to his definition. He proceeded to collect figures for the earnings of those consultants, and it was upon those earnings mainly that the Spens Consultant Committee made its decision. When we turn to the early days of the National Health Service we suddenly find there are 5,000 consultants. ——Professor Bradford Hill's analysis was based on a sample of those who sent in a return—a bit more than a thousand —those who gave complete returns for their net and gross earnings during the 1939 period, covering the whole range of the fields of medicine, surgery, the major specialties, radiology, and the like. It was regarded by the statisticians as a significant sample. Those were facts, those were earnings. It was evidence of the gross earnings, and the variation in overhead expenses, very high in some branches like radiology, lower in medicine, and so on. That was of the 4,000 or 3,000 odd consultants who were asked to return this information. It was a smaller number, but regarded as significant, and on that the mean income was calculated; on that was built the merit award system in order to bring earnings throughout the age periods up to the earnings which had been derived from free practice, in the free market as it were, from consulting fees.

Professor Jewkes: I am afraid I put my question very badly, Sir Harry. What I was meaning was that in fact Professor Bradford Hill took the sample from 1,700 persons whom he believed constituted virtually the whole of the group of consultants in England in 1939.

4096. *Chairman*: In fact, Sir Harry, I think he sent a form to every single person when that list was compiled. This is what he says: "All the part-time visiting staffs of local authority or voluntary hospitals".——There were many more at that time I am sure.

4097. *Professor Jewkes*: What is the explanation of the big jump in the number of consultants?——1,700 was not the number of consultants in 1939 in this country. There were many more. Since the Act a great number of new consultant posts have been created. At the beginning of the special Merit Award Committee of which I was an original member, and remained a member until last year, the number then was probably in the whole constituency in England and Scotland something like 4,000. I am just guessing the figure, but the number has gone up considerably because consultants have been appointed now throughout the whole of the realm to the smaller centres where no consultant previously existed. These are people who have gone through this long and arduous academic and practical training which the consultant life still demands.

4098. Is it possible that when the National Health Service was instituted it did mean that a number of people who before the war would not have been regarded as consultants then entered the consultant class?——No, I do not think so.

4099. *Sir Hugh Watson*: I was rather interested to round off Professor Jewkes' point—we were told by Lord Moran the other day that there are now 6,700 consultants in England and Wales, and a number, to him unknown, in Scotland in addition.——*Mr. Harold Edwards*: May I say on this point that the term "consultant" is a new term, and we were not consultants before the war, until we retired we were consultant surgeons. I have not read Bradford Hill so I am speaking without adequate information, but I should suspect that there was some disparity caused by determining exactly what a consultant was in those days. We were honorary surgeons or honorary physicians unless we were in full-time service, and I imagine that there may be as a result of the great difficulty in defining this term some disparity in the numbers before the war when this was done, or just before the war when there was Bradford Hill's review.

4100. *Professor Jewkes*: No, in connection with the Spens Report.——Just after the war.

4101. *Chairman*: It was done after the war in relation to people known to be practising just before the war.——I recall that, but I think probably the difficulty in defining what was then a consultant, which is entirely a new term since the Act, might have been one of the reasons

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at least for this difference in numbers.—*Sir Harry Platt*: I would submit that the constituency existing at the time of the Spens Report did not represent any dilution. The names were taken from the directories of the hospital staffs, both of the voluntary hospitals, teaching and non-teaching, and of the local authority hospitals, and really included men of consultant status in every sense of the word who were not practising in general practice.

4102. *Sir David Hughes Parry*: Could I put it in this form? I understood you to say that there were full-time salaried doctors on the staff of local authorities whom you would not regard as consultants, is that right?——A mere handful at the time.

4103. Have you any idea of the numbers of those who are graded now as consultants?——Most of those by virtue of long experience have received consultant status.—*Sir James Paterson Ross*: I wonder whether I might put in a word here to help on Sir David's point? I think we would all agree now with what Sir Harry has said, that before the war many of the local authority hospitals were, we would regard, under-staffed, and staffed by men who had not gone through this training, men who did not have the Fellowship of the Royal College of Surgeons, for example. And there is no doubt whatever that one of the effects of the Health Service has been to upgrade the hospitals in different parts of the country so as to give a more uniform improved service—in surgery we are talking about particularly; and it is for that reason I think, among others, that the number of consultants has increased. It is not the increase in the numbers of consultants in the great teaching hospitals, the well-established hospitals, but the improvement in the standard of the surgeons up and down the country, the increase in the facilities available to patients uniformly all over the country. I think that is one of the great changes made by the National Health Service.

4104. *Chairman*: That you would regard as a considerable advance, would you, Sir James?——Yes, Sir.—*Sir Harry Platt*: Barrow-in-Furness, which Lord Moran used to quote, both in Spens and in the early days of the Merit Award Committee, now has a complete range of consultants, younger men, highly trained, appointed since the Act, and that is the great triumph.

4105. *Professor Jewkes*: I think the point I am trying to get clear is this. After all you were on the Spens Committee and you know. When you were discussing the level of consultants' earnings under the Health Service, were you thinking about 1,700 people, or were you thinking of 4,000 or 5,000?——I cannot remember the constituency at that date. It was more than 1,700. We were thinking of the whole lot who held reputable hospital appointments and who were practising as consultants in the sense that they were consulted by general practitioners.

4106. You were thinking of more people than Dr. Bradford Hill had taken into his census?——We regarded that as a sample, those people who took the trouble to fill up the questionnaire and return the details of their incomes.

4107. You were thinking of the numbers in the population from which Dr. Bradford Hill decided to take the sample?——Certainly.

4108. *Sir Hugh Watson*: We have had a great deal of evidence about the translation into modern terms of the recommendations of your committee. It has been suggested to us that the way in which to apply that double-headed recommendation of the Spens Committee is that this Commission should recommend that the medical profession should have remuneration based on the value of money or on the incomes earned by comparable professions today, whichever is the greater. What would you say to that?——That seems to me to be prejudging the whole situation, as it were; that is a plan of action which the Commission will have to consider, because I think we all appreciate the very great difficulty you are facing in this quite novel situation. But it seems to me again one of these sweeping statements. In other words, are we to take the income of Sir John Simon, as he then was, or Sir Hartley Shawcross, and so on, at the Bar, or are we to take the high salaries of the great leaders of industry and corporations whom I need not mention? But that is your job. I am not sure that the medical profession, and particularly the consultants for whom we speak, really feel that our case—and the Royal

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College of Surgeons is not putting forward any extreme claims—should be judged by these other yardsticks.

4109. By the yardsticks laid down by Spens you mean?——On the spirit of the advance from that base, which was, as we said so many times, the equating of a salary with the income earned in free conditions.

4110. *Chairman*: Sir Harry, I think I have got the sense of what you are saying. How do you consider that there should be some sort of relationship established between the earnings of consultants, the average consultant if you like, and those of other branches of the profession, or do you consider that they are so far out that it is impossible to compare them?——There should be a relationship with those in other branches of the profession, in general practice, who deal with the sick man as an individual.

4111. Other branches of the profession, those in general practice on the one hand, and earlier stages in your own branch of the profession, for instance the registrar, senior registrar, senior hospital medical officer, and so forth?——During the period of training which leads up to the final act whereby a man becomes a consultant, obviously I think we would agree that the scales of remuneration during the time a man is in *statu pupillari* should be related to the general economic pattern.

4112. I still do not think you have quite answered my question, and I was not quite sure you had answered all Sir Hugh's either. Are you maintaining that there should be a relationship or that there should not be a relationship between the consultants and, if you like, first of all the general practice hranch of the profession?——Yes, I think it was felt in the Spens Committee, and later in the one on general practice, that there should be a lesser gap between the general practitioner, the experienced general practitioner, and the earnings of the consultant than had existed in the older days. The profession felt that as a whole.

4113. The general practice report was actually a good deal earlier, not later than the consultant one.——Yes.

4114. But I am talking about what you feel now. Do you feel there should be a relativity or relationship between the earnings of the consultants and those in general practice?——Yes, all those who deal with the sick person as an individual who have a totally different contract in life from those who hold posts in whole-time services which have existed for generations, and who are not dealing with the sick man.

4115. *Sir Hugh Watson*: I do not follow what you mean. Who are these last people to whom you refer?——Medical officers in the Armed Forces, medical officers in the public health services—I shall probably not be popular for saying this—in Whitehall and elsewhere, for whom the highest academic qualifications are not necessary for that way of life.

4116. *Chairman*: Nobody was suggesting that any of these figures should be identical. The question is whether there should be a relationship, whether they should really have any bearing to one or the other at all?——I suppose in justice there should be some relationship in order not to create a feeling of injustice throughout the profession as a whole.

4117. *Sir David Hughes Parry*: It is not a question of envy or injustice, but a question of recruitment into different branches, is it not?——No, because the recruitment to the consultant life—and I purposely avoid the word "ladder" which my friend, Lord Moran, stumbled into—represents a series of hurdles; first of all the years of academic study and practical experience which are necessary to take the Fellowship or Membership of the Royal College of Physicians, and then the long period of hard training, and that is something quite unique.

4118. *Chairman*: Well, Sir Harry, there are now quite a lot of people who are whole-time consultants, are there not?——Yes.

4119. And the relationship as far as can be judged between the average whole-time consultant and the average general practitioner in the same sort of age does show a very considerable financial recognition of those facts as far as the whole-time consultant goes, is not that so?——I should think so. Of course, even before the war—before the Act—there were a very considerable proportion of general practitioners earning substantial incomes, and quite a number

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of consultants, as Professor Bradford Hill's analysis revealed, were earning quite modest incomes. And that was not necessarily during their lean years, because that always applied; so that I do not think there has been a revolutionary change in the broad picture.

4120. *Sir Hugh Watson*: I may be wrong, but I think what the Chairman was trying to get at was a much simpler matter than I think you thought. I think the Chairman's question was really this. Do you think there ought to be a relationship between the remuneration of general practitioners and the remuneration of consultants?——Oh, yes.

Sir Hugh Watson: I think that was your question, Sir?

4121. *Chairman*: Yes. I was trying to find out to whom you thought consultants should be related?——The general practitioners undoubtedly, because that is the same kind of clinical life with a different setting.

4122. *Professor Jewkes*: We have got on to the matter of principles a bit earlier than I had expected, but since we are discussing it may I ask you about another possible principle. The statisticians tell us that the real income per head of this country has gone up by 20 per cent. in the last ten years or so. Vulgar people would just say that we have never had it so good as a community, and there are people who are talking about the possibility of doubling the standard of living in the next twenty years, and so forth. The medical profession would not want to see itself cut out of some share in the steady increase in the national prosperity, would it? If you only had your earnings adjusted to the cost of living that would be tantamount to saying: "We are cut out of the general improvement in national wealth."——No, I think it is quite reasonable, but, of course, the profession for two thousand years has set its own fees in a way irrespective of the rise in per capita income of the nation, and naturally with increasing prosperity the doctor or the consultant would adjust his fees accordingly in the conditions of a free society. I think I rather regard your question as a little bit too broad to be answered.

4123. I was only thinking that since the level of medical earnings has been fixed, as you say, for 2,000 years in a free market, and since now other tests have to be applied, other principles have to be observed, that the one I mentioned might be one that anybody that had to make decisions at the present time should have in mind. For example, as I say, in the last ten years there has been this real increase in income per head in this country of 20 per cent., or thereabouts, and no one I think challenged the point that doctors have not had any share in that. Is that felt by the medical profession to be unfair?——I suppose that where remuneration comes from the State there is bound to be a lag in increases in remuneration. But I think you can see from my thesis that there is still a sense of uneasiness with this concept of a professional service for consultants, and the concept of the State as a whole and complete employer.

4124. *Sir David Hughes Parry*: Could I suggest another principle that may have to be taken into consideration? Would you agree in the earlier days of the consultant's career there is a much greater economic security for him than there was? Would you agree to that?——Yes. Of course with spectacular inflation the economic security which arose out of Spens is now rather a bare and austere type of security at senior registrar level as we say later on in our memorandum. There is still a lean period for the young consultant in his earlier days, before he can either acquire some consultant practice or before he can qualify for a merit award.

4125. But there is much greater security really?—Yes, unquestionably.

4126. Can I take you a stage further than that? There is from the fact that there is a guarantee of seven or eight increments of salary for consultants an element of greater security in the early days, and even perhaps in the later days of the consultants?——Yes, except we have still to recognise that the security of those in higher training now categorised as senior registrars is a security in which a time limit has been set for the period of training. And if at the end of four or five years still they have not obtained a consultant post that security in theory and in practice goes, vanishes.

4127. *Chairman*: We have heard a good deal of that problem, and we will shortly be coming to that particularly and separately.——The President will

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agree the College is concerned, deeply concerned, over this problem.

4128. *Sir David Hughes Parry*: The point I was making for was this, that it might be that some discount or allowance ought to be made for that security provided it is an adequate security.——Of course, yes, if you adopt this fundamental concept of the State as the employer. This, of course, is something that would be quite reasonable in view of the training he receives. But that line of argument is very repugnant, of course, to the age-long traditions of the medical profession, and it must be so, and it would be repugnant, Sir David, to the profession of which you are so distinguished a member.

4129. *Sir Hugh Watson*: Of course I quite accept that, not being on the same basis as either you or Sir David, but at the same time you have already indicated one way in which the National Health Service has benefited this country to a great extent, and that is by spreading the consultant service right throughout the country. You agree I am sure for the Royal College that the National Health Service has come to stay, and the College will accept that they are now on a different basis from what they used to be, however much that basis may compare unfavourably in their view with what it was before the war?——Sir Hugh, I do not think any scientific outlook would agree that something that has come to stay should remain unchanged. It is surely within possibility that a considerable review, reorganisation and improvement of the fundamental structure of the National Health Service might take place in years to come, and that might result in something like a reversion to the old state of affairs, as, for example, the situation which exists in the United States, Canada, Australia, New Zealand, and so on.

4130. We are concerned here with remuneration, and perhaps that is a wide enough problem for us to deal with. Now may I take you a little bit out of turn, and go to your paragraph 25, where we asked you how you would suggest that remuneration in future should be dealt with. You do not deal with it very specifically, but you do suggest in paragraph 26 that "It should not be impossible to devise an Arbitration Council of the highest level. . . ." You probably know that there is a general principle that it is not thought that arbitration is an appropriate way of dealing with remuneration of people in the higher salary brackets who are employed by the Crown, and we are looking around therefore for some other way. Now you probably know the British Medical Association have suggested something of the nature of the Coleraine Committee. You are familiar with that?——I am not. I do not know whether my colleagues are.

4131. *Chairman*: You know what it is. It is the Committee arising out of the adoption by the Government of the recommendations of the Priestley Commission on the remuneration of the Civil Service.——Yes, now I remember.

4132. *Sir Hugh Watson*: The Priestley Commission recommended that there should be set up a committee which would be purely advisory, and that is in fact the Coleraine Committee. The British Medical Association suggest that there should be set up a body apparently comparable to that which would have a Chairman possibly with a legal background, that it should consist of other members agreed by the Ministry on the one hand and by the profession on the other hand, and that it should base its deliberations on an index which is to be agreed. We have not had an opportunity of hearing from the British Medical Association as to what they mean by that index, whether it is to be an index based entirely on cost of living, or which of the many varieties of indices, with which Professor Jewkes is familiar, they are dealing. Would you think that some such tribunal composed of eminent people, in which both the Ministry and the profession would have confidence, working in an advisory capacity would ensure that the future remuneration of your profession can be adjusted without the difficulties which have attended it in the last ten years?——I should have thought that the sort of thing that you outline would be covered by our reference in paragraph 26 to an Arbitration Council.

4133. You see unfortunately it is an essential principle of arbitration that if you go to arbitration both sides agree to be bound by the decision of the arbiter. ——I think "Arbitration Council" here probably should be in inverted commas; it is just a description of a body which is not within the Whitley machinery.

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4134. *Chairman*: Arbitration in this respect does not mean arbitration?——No, it means discussion.—*Sir James Paterson Ross*: Yes, fact-finding was our idea—an advisory body.—*Sir Harry Platt*: I think Sir Hugh has put forward a very interesting and very acceptable point on review machinery.

4135. *Sir Hugh Watson*: Please do not run away with any too happy idea about this, because we have not had an opportunity of testing what the B.M.A. really have in mind about this matter. But you would feel generally that, supposing this Royal Commission were to make some recommendation which was acceptable to the profession and to the Government, one that would be continued and reviewed by a body such as the B.M.A. suggest, or some such body, that would be a reasonable way of dealing with the situation?——I should think eminently reasonable, and most acceptable. You did ask about paragraph 25. The Royal College of Surgeons did not put forward any figures because we understand that our sister College, the Royal College of Physicians, had entered that field. We are told that they have suggested a scale of increments on the present remuneration.

4136. In other words, as you said earlier, you are not talking about half crowns?——No.

4137. Like Sir David you are talking about guineas rather than half crowns.——Yes, the old fee.

Sir Hugh Watson: Now, Sir Harry, I think that deals largely with the questions on the principles of remuneration, unless you or any of your colleagues wish to add anything on these matters. I think we see how you feel about this.

4138. *Chairman*: I would like to come back to one point that Sir David raised on this question of principle. He did refer to the question of recruitment. I was not quite sure, but I rather thought that Sir Harry felt that the question of recruitment, the supply of suitable candidates, both into the profession and the question that you did not answer in your memorandum about excessive resort to one branch or another of the profession—I was not sure that Sir Harry felt that had very much to do with it.——I do not know whether Sir David meant general recruitment to the medical profession, because my colleagues are prepared to speak on that. I also think any change in remuneration would make it less attractive. Our evidence really emphasises the importance of tradition as a stimulus to the entry into a learned profession, particularly of father to son, and so on.

4139. *Sir David Hughes Parry*: Was paragraph 16 dealing with recruitment to the whole of the profession?——Yes, we were asked one of your questions, and we answered that to the best of our ability. I think we do recognise now the competition for the type of medical student, the sons of doctors, and the ones that we mentioned here, who have formed the profession for generations. They are now subjected to a tremendous bombardment of propaganda on other ways of life, great supplements in "The Times" and "The Manchester Guardian". The son of a doctor who has seen his father working hard says: "I am going to be a Cockcroft or a Chandos; I am not going to attempt this arduous life of a doctor". I think that is a new factor which may influence the quality of our recruits.

4140. Does paragraph 16 represent the view of the Royal College on the type of person that needs to be recruited—particularly the last sentence, which is a little scathing?——Yes, intentionally so.

4141. Now I wonder if you could give figures to support that, or is it merely the result of your general impression, is it pure theory?——I think my colleague, Mr. Harold Edwards, who is engaged in undergraduate teaching, will answer that.—*Mr. Edwards*: There were two questions there, were there not, Mr. Chairman? First of all the numbers and secondly the quality. Numbers are easy to report on, and as far as my own medical school goes I have got out the figures here which are very interesting to me at least, and I hope may be to the Commission. Now in 1949 we had 625 applications to enter my medical school. In 1958 we had 397. Now we work that down to an even better figure. There were in 1949 11·3 applications for each available place, and in 1958 7·2 applications for each available place, so although these figures are for a small

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section in one London medical school they do show a trend in that less students are applying to enter medicine. As regards quality there is no yardstick. One can give only impressions, and one has to exercise for oneself the thought that students are not what they were when we were students. But even allowing for that we feel that quality has deteriorated, though it is impossible to prove this—there is no proof available, there are no figures available. It is only an impression, because in medicine what are you going to compare quality with? What are your standards? Is the best doctor going to be the man who has vast human sympathies, or the boy who is top of his class and easily gets a State scholarship? What are your determining factors? It is what Sir Harry implies, it is not snobbishness at all, that the social background of a doctor is so important. In his work of treating patients he has first of all a human problem, and secondly a scientific problem. Our impression is that if you take that as a yardstick which is not measurable in terms of science, but only in terms of impression, that the standards of medical students are not as good as they were. I would not say they are less industrious. I think they are more industrious, possibly a bad thing. I would not say that they are not better at examinations, they probably are. If you take the other interesting point, the number of students now who are financed by some body or other, mostly the State—you know of this, of course, but it is interesting—in our own medical school in 1938 27 per cent. of the students were financed by some body or other, and now it is 74 per cent.; and the number of financed dental students has risen even more because of the increase in places at dental schools. It means, of course, that you are selecting the boy who is extremely good at scholarship, but who is not necessarily the best boy to train for this type of profession. So I would say on the whole our impression is that there is a different standard, anyway a different type of individual who is going into medicine now than was the case before.

4142. Still you have an opportunity to select one in seven, and it may be that it is not the quality of the student but the quality of the selection that may be wrong?——That is a point which we could debate all day, the method of selection. You first of all have to base it on scholarship, there is no other way. Perhaps you may have 250 students applying at your medical school, and you are not going to interview all those. You have to take the first 60 based on scholarships and headmasters' reports and so on; and most of us believe that the right way then is not the intelligence test and writing essays, but the interview. I defy anybody to determine when they see a boy at the age of seventeen what he is going to be like at the age of twenty-three, and yet that is the best method we have of doing it, at least we think so. So that you are quite right in that there is a selection, but we are not sure it is the right selection. And as I say, and Sir James, my President, would say exactly the same thing about it, I am sure, that we have exercised a very great deal of effort in selecting the best students.

4143. Have you any ideas as to the number of students whose fathers are in the profession?——It is a diminishing number, but I have no figures.

4144. Because there have been suggestions that those figures are going down possibly not only in this country but elsewhere as well?——There is another factor, of course, and that is that the general practitioner is outside the scale of income which enables the cost of his children's training to be supplemented by the State. So the type of individual whom we want, that of the doctor's sons who are brought up in the atmosphere of medicine, becomes less and less as the doctor is unable to send his son for six or seven years training. That is the economic reason why the standard is a different standard from what the medical student used to be.

4145. But you can recruit now from a much wider field having regard to these subventions from the State?——That is absolutely true, that you have a wider field but a wider field does not necessarily mean a better field, because you have a changing level of people who are coming in, being financed from outside and knowing they are being financed from outside. I do not say this is a bad thing that you have a wider field; it is probably a good thing, because it is a good thing, I believe—it is only a personal view—to have people in this profession from all fields but not

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substantially from one group of social background which we are getting now.

4146. *Chairman*: You say you are now getting students substantially from one group?——Yes, I would have thougbt we are getting them. In fact, if you take their history from scbools and the schools tbey are going to you will see tbere is a difference as compared with before the war.

4147. Certainly there is a difference. Tbere is no doubt about it, but they are coming in now substantially from only one social group, are they?——May I put it this way, Sir. I am not meaning this snobbishly but the group with the lower social background which we all understand is greatly different and that social background is now occupying or now composing the greater percentage of people who try to get into medical scbool whereas before tbat was a very much smaller percentage.

4148. But you are still exercising a considerable degree of selection by tests, on merit of some kind?——Yes, Sir, but I am now not talking about the people who are selected but of people who enter and appear for selection.

4149. All the applicants?——All the 500 or 250 wbo appear from which we would choose 60.

4150. *Sir David Hughes Parry*: And other things being equal you would prefer the son of a medical man; you would give preference to his admission? ——Certainly, in the interview. He is brought up in the atmosphere, perhaps going back to his grandfather.

4151. *Chairman*: Have you any figures about applications going further back? You just gave 1949.——I have not the applications for admission in 1939 but they would be far less in 1939 than in 1949.

4152. These views which you give seem to be paralleled all over the world and I think in the United States it has been remarked on. But you would still be getting more applicants now than before tbe war?——Yes, I would say more now than before the war but that is only an impression.

4153. We had figures in Scotland that bore tbat out very much.——It is very easy to get figures. It did not occur to me to get the number of applications.

4154. *Mr. McIntosh*: But you feel the number of applications is falling off now according to the figures you give us. Would you be prepared to express an opinion as to how much this is affected by the prospective student's knowledge about remuneration?——I think that is an unanswerable question, Sir. I think that it must have a bearing because we all of us should have knowledge of putting children into some profession or trade; it is very largely father's choice and not the individual's choice. He has to make his choice at 17 and it would appear that one of the reasons bebind this is an economic one.—*Sir Harry Platt*: If I might just say, Sir, I think this waxing and waning of entries to medical school is a mucb more complex problem today, as indeed it always was. Long experience in a great provincial medical school, my own in Manchester, I think illustrated that, when, during tbe great depression periods in the cotton trade, using that as an example, tbe industrialists sent their sons into the professions—accountancy and medicine—instead of keeping them in the family firm. I remember being very struck by that. Now this question of decline, I think, would lead the Commission into all sorts of bypaths. The doctor's son has to compete for a State scholarship today like the son of anybody else. I think the clientele of tbe London medical scbools differs a little over the last forty years from that of the great provincial medical schools where we have always had a cross section of all classes and I do not think tbat bas cbanged very much. But the point whicb I did make is that tbere is this tremendous competition for the able boy or girl and for those from the background whicb we feel medicine still needs, with this vocational sense, the sense of being set apart. It is the fascination of the engineering and nuclear age which affects our recruiting.

4155. *Sir Hugh Watson*: That, of course, is affecting the recruitment to many otber professions besides medicine. ——It must do.

4156. *Professor Jewkes*: One of the documents which has been put before us regarding recruitment is, of course, the report of the Willink Committee. There seem to be various ways of interpreting the conclusions of the Willink Committee but at least one way of interpreting them is that there are, in fact, sufficient doctors

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at the moment. One of the recommendations of the Willink Committee, as I understand it, is that perhaps entries to medical schools should be cut down slightly. Do you feel that the Willink Committee has got the right story here?——*Sir James Paterson Ross*: It is very hard to answer.—*Mr. Edwards*: There has been a good deal of discussion; there are many factors. I do not think you can pin down one factor. The Willink Committee might have attempted to do that.

4157. *Chairman*: Might it perhaps be true, Sir James, that in some branches of the profession, perhaps in the branch of general medicine, for instance, there might be a need for fewer doctors than look likely to come forward under the present circumstances, whereas in other branches—for instance neuro-surgery—there might be a need for more; that the conclusions of the Willink Committee are not necessarily of unanimous application throughout?——*Sir James Paterson Ross*: I think that is perfectly right, Sir. You can see from the returns, even those that are prepared by the Ministry about the vacancies in certain specialties, that there is more room in some than others. There is no question about it and I think people are often prepared to switch from one to another—if they are wise, they are—at least they have always done that in the past.

4158. You are speaking today for the surgeons. The consultants as a whole are represented rather by the Joint Consultants' Committee. I wondered whether you would find it easier to answer just from your own surgical branch?——Within surgery I think there is room in some specialties more than in others. I think that is perfectly true.

4159. *Professor Jewkes*: You know, Sir James, that was rather shot at you without notice. If the Royal College wish to make any comments subsequently upon the whole question raised by the Willink Committee I, for one, would be very grateful to have them.——We would be very happy to go into that carefully. We have already had an interest in it but I do not think we have ever discussed it together to get a considered opinion about it. There is no doubt that the tendency for certain men to feel that there are more opportunities elsewhere is something which has been brought to your notice a great deal. I mean people emigrating when they are really pretty well trained and it is not because they are not good that they go abroad, it is because they feel there are greater opportunities. That is the same problem, is it not, this question of finding a footing in this country.

4160. *Chairman*: Such figures as we have had about emigration and immigration do not show any marked change in the position.——As I understand it, Sir, there has been a fluctuation. There was a great deal of movement away in the 'thirties and then it dropped, I think, in about 1947, some time like that, and then it is tending to rise again now. I think that is the general impression but it is hard to get reliable figures about that. Having been recently in Australia and Canada myself I was struck with the number of very good men who have recently moved from this country to Canada and Australia. In conversation with them I went into this extremely carefully. I asked them why were they not able to do these things at home, both in general practice, that is, and in surgery and the answer was they could not afford to run their practices in this way at home. I cross-questioned them very carefully about that and I came to the conclusion that what they were telling me was absolutely true.

4161. In general, Sir James, I do not think there would seem to be any great disparity between doctors as a whole and the community as a whole as regards emigration?——I do not know that.

4162. But would your impression be that at least the top doctors are finding these extra opportunities abroad more readily?——No, Sir, not necessarily, they are in all grades. I can think of several in my mind now who have gone to consultant posts in other countries, but also I am thinking of general practitioners and quite junior ones at that who just were dissatisfied with their opportunities here and have found better opportunities abroad.—*Sir Harry Platt*: I am sure that is true of general practice. When I was in South Africa last year I was quite surprised to find the number of young men, of course quite a number of consultants, but others in general practice, who had gone out since the war to South Africa where the conditions of general practice are most attractive, even

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in the native reserves, very attractive indeed.

4163. *Sir Hugh Watson*: There always was, Sir Harry, was there not, what you might call a considerable export of doctors from this country to India?——Yes.

4164. Which is now closed.——*Sir James Paterson Ross*: They did not have educational facilities in India like they have now, I think that is partly the answer. They now have their own medical schools.

4165. What I meant is that one of the recognised outlets for a qualified doctor in this country was to go to the Indian Medical Service. That is now closed and to some extent possibly that gap is being filled by Canada, South Africa, and other countries.——I suppose there always will be a movement. It is a question whether it was for the same reason. Most of the people in the past went mostly for adventure and I think now to some extent it is economic. They like the conditions of life as they are in medicine in these other countries better than the conditions here; that was made perfectly clear to me. They were not people who were emotionally unstable or anything like that, they were really giving me hard facts.

4166. *Chairman*: You mention South Africa; as far as we can judge, at least we are told on figures that are a bit difficult to interpret, that South Africa is one of the countries from which there has been a good movement to this country.——Sir Harry mentioned South Africa. I was in Australia and Canada.

4167. It so happens that South Africa was one of those countries from which there has been a good movement to this country.——*Sir Harry Platt*: In medicine?

4168. Doctors. Does that surprise you?——You mean British graduates who had gone out there and then come back?

4169. I do not think it is possible for the statistics to be as complete or thoroughly dissected as that but South Africa happens to be one of the countries in which the net movement tends to be this way. That rather surprises you I gather?——There is, of course, we all know, a very tense political situation there which intimidates some.—*Mr. Edwards*: May I just say one thing. Sir Hugh spoke about the Indian Medical Service. Its members were really on reflection not recruited from this part of the country. I think most of the I.M.S. came from Ireland or at least a very high percentage of them, not that that is material.

Chairman: The trouble about the statistics, Sir Harry, is that when students come here from overseas they are counted as students and when they go away, having taken their degrees, they are counted as doctors and it always looks as if more doctors go than come.

4170. *Sir Hugh Watson*: Could we pass to another topic, Sir James? I am not sure whether this is for you or for Sir Harry. You laid stress in your memorandum on the desirability of having the consultant service predominantly part-time?——*Sir James Paterson Ross*: Yes. Either of us, I think, can talk about that but again Sir Harry represents in a way the part-time consultants and perhaps I represent in a way the University members that I mentioned earlier this morning. I am quite convinced myself, although I am a University professor, of the importance of the part-time consultant in medical schools as well as in the Service as a whole.

4171. This was made quite plain to us by the Joint Consultants' Committee when they gave evidence to us some months ago. The principal point that they stressed was professional freedom?——Yes, there is freedom, but if I may speak purely from the medical school point of view for the moment, I think the part-time consultant and the part-time clinical teacher has a slightly different attitude even to his clinical work. In other words, he has to be capable of managing his patient from beginning to end and instil into his students an important attitude of independence; whereas there is no getting away from it, the academic teacher does tend to rely, to some extent, on his assistant for some details which, I think, the student should learn for himself and learn to be independent about. I hope I am making this point clear?

4172. Yes.——That is why I think that a part-timer is of tremendous importance in the teaching field. Now, in regard to practice I think it is important

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from the patient's point of view that he can feel that he can get an independent opinion. As Dr. Geoffrey Evans used to put it, he can buy half an hour of a consultant's time that he knows is entirely his own because there is, after all, a great difference between a private consultation and a visit to a hospital. A consultant gives the patient the same treatment and the same attention whether it is in hospital or in his consulting room, but the patient feels that he can bully a consultant much more if he has him for half an hour in his consulting room and he gets more satisfaction from that. I think that is the important thing, for the patient to feel that if he can afford it and wishes it, he can approach his consultant and cross-question him in a way that perhaps, would not be possible in the hospital where there are a lot of other patients waiting.

4173. I am very interested that you should have said that the patient can bully a consultant in his consulting room because I was talking recently to an old friend of mine in Liverpool, a doctor, and asking him what his reaction was to the National Health Service; and he felt he was being bullied by his patients. ——A practitioner, I think, often feels that, because the patient has the feeling that he has made a contribution and therefore the doctor should be at his beck and call at any time. But I think that is a question of sending for the doctor and the doctor sometimes feeling that he is being sent for unnecessarily. I do not think it applies to consultants in the same way.

4174. I see. Sir James, in your paragraph 13 you deal with one aspect of the difference in the way in which full-time consultants and part-time consultants are treated by the Health Service in the way of their remuneration and so on. You point out that if the surgeon is to keep abreast of advancing knowledge he needs leisure to read, to write, and to travel. He must, therefore, be able to look forward to a standard of professional earnings which allows him to incur such expenditure without sacrificing essential family needs. What point are you exactly making in that paragraph?——He has got to have a certain level of income coming to him which enables him to indulge in these things. He must not be so taken up with routine work that he has no time to read and study for himself. He must be able to visit other clinics more certainly than a practitioner who is not a consultant. Also, I think, we do mention here the question of entertaining his friends from abroad who come because they are making essential contacts and it is absolutely necessary that that should be so too. I think that should come under what we might call: "professional expenses" for which we think an allowance should be made.—*Sir Harry Platt*: If I might take over there, I go back a longer span of years than my colleagues, just immediately before the first world war, and it was after the first world war that the travelling of consultants became a habit. Indeed, we have now arrived at a stage when it is an obligation. At one time, as those of us well know who go back a bit, the cost of foreign travel in the '20's and '30's was comparatively small but today those things are exceedingly expensive—travel, the fares and staying in hotels, and so forth. The big income earners in the free market in the old days felt the cost of travel very little. I do not put myself in that category but I must have spent over my forty years a lot of money in foreign travel, five trips to America, innumerable continental visits and so on. It was well worth it. Now it is very necessary that that goes on. There are congresses, there are visits of small surgical colleges to bigger colleges, special centres on the continent and in the United States. It is the life's blood of the consultant's life and it is now exceedingly costly and represents quite an item out of the part-time consultant's income or full-time university consultant's income which many shrink from because it is an expense on top of their basic family needs.—*Sir James Paterson Ross*: Of course in industry, as you know quite well, better than I, all these things come under expense accounts and I think that is how people manage to do their necessary travelling because it is so expensive.

4175. Sir James, the Commission are fully conscious of the point which you and Sir Harry make, that it is nothing like so easy now for medical men to go abroad as it used to be because of the expense of travel and hotel accommodation. But there are societies and bodies and funds available which provide grants for some of these things, are there not?

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——*Sir Harry Platt*: Yes, for a few individuals; there are endowment funds of the great teaching hospitals here and there and actually a certain amount is allowed in the budgets of the Regional Hospital Boards and the Boards of Governors. But it is very little and it very rarely covers the complete expenditure now incurred: it is, I think, part of the modern inflation. I, myself, had part of my post-graduate surgical training as a young man before the first world war in Boston at the expense of my father who could very well afford it in those days; but the cost of living was then really infinitesimal. Today it is formidable to do that sort of thing and there are not Fellowship and endowment grants galore for all those who have to go to international and national congresses.——*Sir James Paterson Ross*: I think I could put it in a nutshell that for the young man training to he a consultant who is going for a year abroad there are these Fellowships and grants.

4176. Yes.——There are in the Health Service, as Sir Harry has said, certain funds—limited funds but still very important and welcome for members on study leave with pay and expenses. But these are not applicable, with certain rare exceptions, to consultants. The only exceptional ones I can think of are in the Universities: sometimes a person who goes to give a course of lectures or is going for a specific reason to another University centre to acquire a technique or to learn something, there is such a grant. But you may just say in general terms that these things apply only to the young man and do not apply to consultants as a whole; they have to pay their own expenses.

4177. *Chairman*: Have you any idea of the size of the grants that the Regional Hospital Boards have at their disposal for this kind of purpose?——*Sir Harry Platt*: Just speaking from memory the Manchester Regional Hospital Board has something like £1,200 a year or £1,500. It has to be set aside out of the budget allocated by the Treasury.

4178. How otherwise would you suggest it should be done, Sir Harry?——The difficulty is to separate the young men who are in *statu pupillari* and those at the height of their activity.

4179. I was wondering how else you might suggest it should be done if it was not to be provided for by the Regional Boards in their budgets?——It should be done for the full-timer if in receipt of a substantial income hy being a non-taxable expediture, quite plainly. Then I think it could be found.

4180. *Professor Jewkes*: You are stressing this point in connection with the whole-time consultant rather than the part-time consultant?——Yes, I may be in a minority about the part-time consultant. I think if he is in receipt at the height of his career of a substantial hospital salary and good merit award and is able to increase that by private practice he should pay for this, as we all have done in the last thirty years, out of his own pocket; but it should be a non-taxable part of his expenses.

4181. Which it would normally he at the moment?——Not admitted always or not admitted in toto. It is argued with great zeal by minor functionaries as to whether a part of it is tourism, part of it the improvement of a man's capacity to practise in the future. It is, in other words, a capital improvement. These are childish and ridiculous obstacles.

4182. *Chairman*: Is it only the whole-timers who get an allowance from the Regional Hospital Boards, Sir Harry?——No. A part-time consultant may get a grant in aid if he has to go to read a paper, say, at a congress in the United States. If it is considered it is good for the regional hospital service, he may get a small grant in aid.

4183. And if somebody is sent and gets a grant in aid from the Regional Hospital Board to travel to one of these congresses, is it taxed?——No.

4184. Well then, surely you are saying it should not be taxed when in fact it is not.——No, Sir Harry, this is a small grant out of a very limited sum of money made available by a Regional Board which may have hundreds of consultants.

4185. What you are saying really is that this sum ought to be larger, that there should be more travel allowed and paid for by the Regional Boards for consultants who from time to time

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should go and represent the country, improve their mind and so forth?——Ideally the subsidy should be to those who otherwise find hardship, either whole-timers or part-timers; I think it is a question of the individual. My own feeling is that a very prosperous consultant—and there are such—should be prepared to find at any rate a greater part of this out of his earnings, being non-taxable, but that is my own personal view.——*Mr. Edwards*: Both from Regional Boards and from Boards of Governors in teaching hospitals there is always a contribution towards expenses but there is usually a very considerable expense over and above this contribution which is not taxed. What Sir Harry is saying is that that amount over and above what you have to pay out of your own pocket should be exempt from tax. That is not the case in full-time posts and it is not always the case for the part-timers that they can be exempt.

4186. *Professor Jewkes*: So if a whole-time consultant goes to a foreign conference it is at his own expense; there is no question at all of his being allowed that as non-taxable expense? ——That is so.

4187. And that is the difference between the whole-timer and the part-timer?——That is the difference, but at the same time it is not always possible even for the part-timer to get exemption because of minor functionaries, as they say.

4188. Whilst we are on the question of whole-time and part-time, Sir James, is it your opinion that there is a right sort of balance between the number of whole-timers and the number of part-timers? Could a hospital run properly if there were no whole-timers or no part-timers? ——*Sir James Paterson Ross*: A teaching hospital, you mean?

4189. Both types.——Yes. There is no denying that before there were whole-time professorial units in teaching hospitals the hospitals got on very well. But we do not think the scientific side of surgery and the advance of the subject was pursued quite as well as it should be. The treatment of the patients was very satisfactory but the advancement was not taking place as it should. There was a great deal of comparison between this country and America and so on. That balance has, to a great extent, I think, been put right by the introduction of whole-time professorial units in a large number of teaching hospitals in this country. I think that the proportion at present existing in many of the schools —not all of the schools, because in many of the schools in London do not have professorial units—but in those that have, I think the proportion is about one whole-time unit to three part-time units. It is probably about the right proportion. In regard to the Regional Board hospitals I do not know that I am really in a position to state how many whole-timers there should be in that service and I would really like Sir Harry, who is very familiar with the Regional Board service, to say about what the proportion of whole-time staff to part-timers in those hospitals should be.—*Sir Harry Platt*: I do not think that one can answer that question and I cannot even remember the figures from my own Regional Board which were published only the other day. In the Manchester Regional Board, of which I am still a member and have been since the very beginning, we have in the new consultant appointments since the Act tended to appoint some of the younger men for a period of three years, until they can settle down, on a full-time contract with the right at the end of three years to ask the Board to put them on maximum part-time; and that has worked very well. It has given them three years to settle down without undue economic strain and when they have established their position they go on to maximum part-time where they are now permitted to do domiciliary consultations and to devote a very limited part of the week to such strictly private practice as may come their way. Without any arithmetical formula we found that a very useful working scheme.

4190. *Chairman*: It fits in on the whole with the needs of the particular hospitals in the service?——Absolutely, but there are certain fields where expensive apparatus and so on is involved, as in radiology where many of the appointments have been deliberately, at the request of the consultant, made on a full-time basis.

4191. *Professor Jewkes*: You would let the distribution settle itself?——Yes, it just finds its own level.

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4192. *Sir David Hughes Parry*: But in certain hospitals you may require a full-time person to go on as such after the three years?——That is really the pact, as it were, with the young consultant at the time of his appointment. It is our practice in our region to give him the assurance that after a certain period he will have the right to ask to go part-time. And it comes back to the majority feeling in the profession, no doubt voiced by the Joint Consultants' Committee, which is reinforced by this Royal College and I think, probably our sister College —I do not know—that the consultants of the country are whole-heartedly in favour of a predominantly part-time relationship with the so-called employing authority.

4193. I notice that the word you used is "predominantly". There must be parts of the service that require full-time consultants apart from this younger generation doing their first three years?——Sir David, if you ask me as an individual whether this service would run at a high level on an entirely part-time basis, my answer would be, yes.—*Sir James Paterson Ross*: May I make a suggestion, Sir? I do not know whether Sir Harry Platt will accept it, but one answer to Sir Hugh's question whether some of the people might remain in whole-time service in the Regional Board hospitals is, I think, probably that most of them who do so are there in an administrative capacity for part of their time. In other words, they are essentially remaining on the clinical side but instead of using the rest of their time for private practice they are using that time for the administrative duties of the hospital. Is that not so?—*Sir Harry Platt*: In the mental health service, that is, of course, common practice. Most of the so-called medical superintendents who are also consultants are full-time but the visiting psychiatrists are predominantly or almost exclusively part-time.

4194. *Chairman*: I wonder whether you can give us a definition for which we have asked before from time to time —what is a consultant? What is a consultant's work? We have so often heard it suggested that consultant work is being done by other people without those people being recognised as consultants.——I think it could be answered if you want a definition, quite simply. The essence of a consultant is, first of all, that he is consulted by other members of the profession and patients are referred to him. He is completely and absolutely responsible for that patient's care. That distinguishes the consultant from anyone else who is in statu pupillari. The senior registrars, many of them men of considerable experience, doing major surgery, carrying out responsible work in fields of medicine and obstetrics and so on, are not in the final analysis responsible for that patient. They have a delegated function. The consultant has the undivided responsibility for the care of a patient. The general practitioner, of course, has the same.—*Sir James Paterson Ross*: I think when we say that the registrar is doing consultant duty what we really mean is that, in fact, this responsibility of the consultant is honoured more in the breach than in the execution of the thing. In other words, the registrar is being made responsible although he is not or should not, in fact, be responsible for a patient.

4195. *Sir Hugh Watson*: So that really, Sir James, while in point of fact, to use Sir Harry's expression, the registrar is in theory in statu pupillari, by the time he has been a senior registrar, as we are told, for 3, 4, 5 or more years he is himself, although not in name, in quality, very nearly of consultant status? ——Yes, Sir. The idea of the senior registrar is that he is in training for a consultant post and so long as there are consultant vacancies he is an applicant for them—it is a matter of supply and demand, as you know, at the present time—and if successful he changes his status but does not change his capability. But he is in charge as a consultant and the natural evolution should be from senior registrar after the fourth year into a consultant grade.—*Sir Harry Platt*: So it is really quite simple. Whatever he does they are not his patients. They are the patients of the consultant who is his chief.—*Mr. Edwards*: And, of course, he only undertakes care of patients at the direction of his chief. If I may I would just like to underline the first part of Sir Harry's definition of consultants. It is derived from consultation with the doctor and not with the patient and so consulting practice is always in association with the patient's own doctor, both in hospital where the only patients

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you see are those who are provided with doctors' letters and in the patient's home. That is the real definition of consultant, I think, but, of course, what Sir James and Sir Harry say in relation to senior registrars is absolutely right. They are delegated and one only allows one's assistants to do certain operations when you feel they are entirely competent to do those operations and even then it is only under direction.

4196. Thank you, Mr. Edwards. You have made that very clear. I have always understood this is rather comparable to the relationship which exists in another profession—a client, his solicitor and counsel. Is that more or less a reasonable comparison?——I have always understood so.—*Sir Harry Platt*: I think the Bar is probably a little more rigid because there are occasions when patients do seek access to a consultant without their doctor.

4197. But by and large. In your paragraph 18 you point out the present unfortunate position with regard to senior registrars and you say there is a moral obligation to ensure their future. We have had this problem put to us by many people and many suggestions have been made. What is the solution of the Royal College to this problem?——*Mr. Edwards*: I think what we are most anxious to do, Sir, is to underline that there is a very big problem here rather than at this moment to suggest any solution to it. I am afraid that is not being very helpful but there is, as we have tried to show, a moral obligation to employ these highly trained men. The obligation particularly refers to those who were given Government grants at the end of the war in order to enable them to become consultants. To the younger people perhaps this obligation does not apply quite so much. But to any one of us—and we all have from time to time to sit as assessors—it is always a most depressing experience: I have just this last week done this thing. The man who got the job, which was a very attractive job, was aged 43; the youngest applicant was 34. There were 26 of them and they were all fully trained surgeons, most of them had their Mastership of Surgery. That is the situation we are facing all the time and it is a problem which we regard as being very much overdue for solution, one which we want to emphasise, one which we want to play our part in pressing at all events. As to the solution of this problem I think there is already some suggestion which has been made: I think Sir James might mention something about that.—*Sir James Paterson Ross*: I think you know that a suggestion has been made that there should be a thorough investigation, perhaps by a working party from the Ministry and from the profession, to look into this problem to try to see exactly the size of it and what the right solution should be for these young men. There is no question, as Mr. Edwards has said, that all of the senior registrars who are time expired are capable of becoming consultants but there are not posts for them. The question at once arises whether more consultant posts should be made so that this anomaly of senior registrars acting as consultants is not perpetuated. But that, of course, is a matter of whether it can be afforded and so on. So in a way we would prefer not to say what we think is the solution of this because it would be pre-judging the solution as far as the working party is concerned, supposing that working party was formed and had to make a pronouncement. On the other hand I think we would like to make it quite clear that we do not think they should go on as senior registrars; we think they should be given security which they have not got at the present time and that they deserve recognition for what they are in fact, that is, consultants.

I wonder, Sir, whether this particular point has ever been made to you by anybody else. A reference has been made by Mr. Edwards to the early days when so many of these men were given grants to complete their higher education because it was assumed that when the Health Service was established there would be a need for more consultants. That was all very carefully worked out before the Service started and it was on these figures that the training of these men was worked out. But what was neglected or perhaps unknown at that time was the retirement rate of consultants in the National Health Service. It was assumed that they would go on as they had before in the voluntary hospitals: men retired at 60, or sometimes after a given number of years on the

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senior staff of their hospital, and the tendency was for them to go about 60 or just over. But, of course, as you know, Sir, the retiring age of the National Health Service became 65 and therefore many of these young men who had expected to get their promotion at the age of 31 or 32 found themselves 37 before they were getting it and that made this great pool of senior registrars. That is why we feel responsible for them because they were, in other words, encouraged to do this thing. In the ordinary way people entering a profession rather look to see whether there is going to be work for them before they undertake a period of training but these men were rather encouraged to do this because it looked to them as though there was going to be work for them afterwards.

4198. *Chairman*: There was actually a calculation about the establishment that was needed to fill the Service in the future and the number of senior registrars bore some relation to that calculation?——Initially, Sir, it did. Is that your question?

4199. Yes.——It was worked out, I think by P.E.P. originally in conjunction with the National Health Service, that was in the latter days of the war. I remember very vividly the whole thing was being worked out at that time.—*Sir Harry Platt*: On the other hand, I think it is true that for those who had given long war service there was the opportunity for a subsidised period of higher training and no limits were set. Is it not also true that the Minister has in the last day or two, recognised that there is a moral obligation to ensure their future by advising Boards of Governors and Regional Hospital Boards now to perpetuate the appointment of senior registrars of great seniority? He has also said it is contemplated that there will be increment on their remuneration.—*Sir James Paterson Ross*: I hope, Sir, that what I said just now will not be misinterpreted. I said I do not think they ought to go on as senior registrars. I think their appointments should continue as senior registrars until something is decided about them. But what I meant is this, it is unjust they should go on until the end of the chapter, until they retire from practice, as senior registrars.

4200. I think, Sir James, it has been put to us by others in your branch of the profession that you are really anxious that there should he a competitive entry to consultancy?——Yes.

4201. That it should not be automatic. ——No, Sir. That is important, otherwise if you appoint a senior registrar you are really appointing a consultant. It must be competitive. The worst objection is that this pool has arisen in that way hecause it was caused ten years ago.

4202. Yes, I think we understand that. Sir Harry Platt, you used several times the words "in statu pupillari". Does that apply to senior registrars?——*Sir Harry Platt*: Yes.

4203. We have not had that particular definition of these training grades before but you would apply it right up to the time they become consultants?——Yes, they are undertaking higher training under the direction of a consultant. They have no ultimate responsibility for patients they treat, that is a delegated responsibility, as Mr. Edwards has said. —*Mr. Edwards*: May I add one thing, Sir, and that is I do hope that the Commission recognises that a trained senior registrar is unemployahle except as a surgeon. He has no alternative. He will not be accepted in general practice as an alternative. That is very important. A second thing about which I would like to make a point is this term "registrar" is very much misunderstood generally. A registrar to us before the Health Act was a man who was in training. Unfortunately, in my view, there are now two grades of registrar —a registrar and a senior registrar. But a registrar is still a man whom you are training; it may take nine or ten years to become a consultant. I think we have expressed our views in our memorandum on that but the unfortunate thing is this: that if a man applies for a registrar's job there is now an implication already that he is in the consultant rank, as it were, which is, we find, an awkward situation. Many of us would like to see a return to the term "registrar", that is a man whom you have selected out of a number for training instead of having these two grades.

4204. *Professor Jewkes*: The Ministry of Health have given us a lot of statistics showing that the number of

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registrars in the hospital service has increased by, I think, 68 per cent., between 1949 and 1956—a larger increase than in any other branch of the hospital staff. Now we know that the appointment as registrar is a short period appointment and you have told us in your report that it is becoming increasingly difficult for registrars to get back into general practice. Taking those facts together to an outsider the position seems to be rather alarming, that you are going to have a problem of frustrated registrars and surplus registrars just as you have one now over senior registrars. I wonder whether this would not give the same cause for alarm?——That is my point. One of the reasons there appear to be so many people in training for consultants is that in the old days there used to be resident surgical officers, resident medical officers, and other names given to these people. But if you call them now "registrar" they become frustrated because they have the impression they are selected to become consultants. We would like a return to some of the grades, resident surgical officer, resident medical officer and so on which they still keep in some hospitals.—*Sir Harry Platt*: From whom the general practitioner was recruited. A few after getting their Fellowship or M.R.C.P. passed on to the present-day senior registrars but even in the old days they could go into general practice in a partnership with these higher diplomas, not with the length of training our modern M.R.C.P. has, and fulfil useful functions. We make that point as one of the avenues closed in this country now is the general practitioner surgeon who is no longer functioning in the smaller hospitals. We do not, as a College, believe we could go back to the old arrangement whereby he was able, unsupervised so to speak, to practise major surgery, but we do believe he might have a place within the surgical team.

4205. As I understand your suggestion it is that there should be more flexibility in the movement between general practice and the hospital in both directions?—Unquestionably.

4206. We are only concerned with remuneration. Have you any suggestions as to how the levels of remuneration could be changed in order to break down what you suggest, as I understand it, is the growing rigidity between hospital and general practice?——*Mr. Edwards*: It is very difficult to answer that question because the thing is all so bound together. If you are talking about improvements in the Health Service we believe that one of them would be this greater flexibility and interchange between general practitioners and hospitals.

4207. *Sir Hugh Watson*: Can I ask you, Mr. Edwards, whose problem is that?——I think the problem is partly a medical one, partly an administrative one, and it must be bound up with remuneration.

4208. Is it an administrative one? Because some of your colleagues have fairly frankly admitted to us that the problem is really one for the medical profession themselves.——*Sir Harry Platt*: It would be in part, Sir Hugh, because we are talking now of the admission to general practice of these young men who have had considerable hospital experience which is or should be of great value.

4209. And vice versa?——He can only get in through selection by the Executive Councils.

4210. But there was also a suggestion that the traffic the other way is also difficult—from general practice into the hospital service.——Very. That, of course, must inevitably be increasingly difficult for those who have not, before going into general practice, acquired the higher diplomas.

4211. *Professor Jewkes*: Ought there to be an arrangement that they should more frequently acquire the higher diplomas for this purpose?——It is a very formidable thing for a man to get the M.R.C.P. and Fellowship. It is two examinations. You are dealing with an honours school.

4212. *Chairman*: More formidable than it used to be?——I think a little. It was always very formidable.—*Mr. Edwards*: I think that the difficulty in bringing general practitioners into hospital clinics can only be appreciated by attending hospital clinics and seeing the problems there, especially in surgery. It is a thing which we should like to do very much if it was only technically possible. But we should certainly feel

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that the general practitioner who has had an adequate surgical experience to entitle him to do intermediate and minor operations should be able to do those, as he used to do before the Act. We feel there is a great gap there which could be filled, not to the same extent because, as we know, surgery that should not be done was being done.

4213. It is really primarily a problem for the profession?——I should have thought primarily it was.

4214. *Sir David Hughes Parry*: It is a twofold problem: bringing people in who have been general practitioners to be consultants and getting those who perhaps started with a view to being consultants into general practice. It is not one way.——Not entirely one way. In fact most hospitals have general practitioners, keen young men who do attend clinics, but it is a little more difficult in surgery, I would say, than in medicine.—*Sir Harry Platt*: I think, Sir, we have to recognise that the way back from general practice to the life of a consultant today is blocked really by the economic factor. Those men who came out of general practice very often lived on their savings whilst they were reading for these higher diplomas. Very creditable it was, and sometimes it took a long time—many efforts to get the M.R.C.P. or the two examinations of Fellowship. It would seem to me today economically impossible.

4215. *Professor Jewkes*: What about movement the other way, Sir Harry, from the hospitals to general practice which you suggest is even more difficult? Can that be eased in any way?——Yes, by education of the profession, by the general practitioner being ready to receive the man who has stayed longer in hospital resident posts than the average and the improvement obviously of the general practice of the future—improved conditions for a more scientific life and access to diagnostic aids, and group practice. Surely the new College of General Practitioners will be giving you evidence on the future of general practice. An increased academic standard of general practice which, I think, we all feel we want, would be a great contribution to this country.

4216. We have this extraordinary increase in the number of registrars as shown in the figures—68 per cent. since 1949. Does this mean that registrars are doing different sorts of work than the work which they used to do? How has this increase arisen?——It is quite easy. I think I can speak from personal experience of staffing matters in teaching hospitals on the eve of war and as it was before I left the staff in 1952. There are greatly swollen establishments. There are far more in the teaching hospitals of these young pairs of hands; they have more time off. The house surgeons have weekends off and time off duty which for my colleagues in our young days did not exist at all. We had to do all sorts of work in addition, e.g. giving anaesthetics for emergencies. That does not happen today. That is one very simple explanation of the great increase in the establishment. An increase in establishment has not taken place in the non-teaching hospitals in the smaller centres. They have difficulty in getting even the numbers they had before the Act and often before the war. It is only by the existence in this country of a great many post-graduates from the Commonwealth, from India, Pakistan, that these hospitals can find these junior pairs of hands of registrars, or senior registrars. The teaching hospitals certainly have many of them, a much bigger establishment of junior people. —*Sir James Paterson Ross*: May I add another point. We gave Professor Jewkes to understand that part of the difficulty is in regard to nomenclature that Mr. Harold Edwards mentioned. As he pointed out, the people that are now called surgical registrars and certainly junior registrars used to be called senior house surgeons or resident surgical officers; in other words they were not called registrars in the past. Therefore a mere change of nomenclature has made a lot of difference and we would like to make it quite clear to the Commission that what we call junior registrars and middle grade registrars do not have difficulty in getting into outside work. It is when they become senior registrars it becomes hard and the longer they remain senior registrars so it becomes harder for them.

4217. I happen to have the figures in front of me, Sir James. These are Ministry of Health calculations. The registrars have gone up by 68·3 per cent.

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As a sort of standard one might mention consultants have gone up by 29 per cent.; registrars have gone up by 68 per cent. What are called here junior hospital medical officers and junior hospital dental officers have gone up by 47 per cent. and what are called senior house officers have gone up by 148 per cent. You see the point I am trying to get clear? Is there a danger that by increasing the number of young men in this section in the hospital staffing, particularly if it becomes more difficult to move from a hospital into general practice, a lot of these young men are going to be left out on a limb? Perhaps it may not be appearing now but it may do in the future?——The vast majority of these you have mentioned just now can move perfectly well into general practice.

4218. Into general practice?——Yes. I think these figures ought to be much more carefully translated into the old nomenclature when they were all termed registrar, about whom we are largely concerned.—*Mr. Edwards*: Also it is the fact if you do not know where to put a man you make him a registrar or senior registrar whereas otherwise he would have had a different appointment. I think it is important to stress the fact that the amount of surgery and medicine going on in hospitals has vastly increased over 24 years. Surgery of the heart, for example, was unknown 10 years ago.

4219. Of course surgery has vastly increased but that has not taken effect on the increase of consultants who have only gone up by 29 per cent. You are telling us younger men can, in fact, find a way out into general practice?——The younger ones.

4220. From registrar downwards?——It is not very difficult up to the second year of senior registrar. But beyond that it is extremely difficult. It becomes difficult once they are senior registrars but when they are just ordinary registrars or junior registrars and junior hospital medical officers they can quite well go into general practice.

4221. *Sir Hugh Watson*: We have been given rather the other impression. We have very definitely been given the impression that particularly if young men have specialised in matters which do not commend themselves to the general practitioner it is very difficult indeed for them to get into general practice for which, as you know, the competition is very severe.——Yes, that is true, but Sir Harry was saying there is going to be a change of attitude to that. I think that part of the trouble is a natural one that they are afraid that a young man who has perhaps failed in his original ambition may be rather a sour character. It is not the training so much as his attitude to life about which they are worried.

4222. Sir Harry mentioned earlier on that these men are regarded as in *statu pupillari* until they reach the consultant grade.——*Mr. Edwards*: Up to the point, I think, of taking higher degrees, if a man has his Fellowship or M.R.C.S. or M.R.C.P. which he has to have before he can be accepted as senior registrar. When he gets those diplomas I think he is looked upon with a little bit of suspicion when he attempts to go into general practice. I should have thought it was time it stopped.

4223. He has burnt his boats?——Yes. —*Sir Harry Platt*: I think it is probably a little easier in medicine. There are many M.R.C.P.s in general practice but now it is increasingly difficult for a Fellow of the Royal College of Surgeons. But, Professor Jewkes, there is one point in the arithmetical problem which is, of course, the nomenclature. You quoted J.H.M.Os. That grade is only used now in the mental health service. It is all very confusing, that although the consultants have not gone up by astronomical figures the figures of registrars appear to have done so. Surgery and medicine, diagnostic and operative surgery has become more elaborate and more complex; investigations take longer and employ a greater number of junior people collecting the necessary data: that, I am sure, is an important factor.

4224. *Professor Jewkes*: I understand that perfectly and that means for these young people there is a smaller chance than formerly that they will become consultants. There are a proportion of them who have to move out at some stage? ——Undoubtedly.

4225. And anything we could do in the way of reviewing remuneration to facilitate that transfer you would think would be important?——*Mr. Edwards*: Might I say it is employment rather than

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remuneration because if you give them remuneration you give them financial stability but not geographical stability. If they are still senior registrars waiting one day with their families thinking that they may have to apply here, then this problem is not really remuneration but employment for them; they are completely trained and able to be consultants. I think that is the problem.

4226. What I am really wondering is when you have solved your senior registrar problem are you then going to have an increased problem transferred to registrars?——*Sir Harry Platt*: You will require a lot of information of the actual potential vacancies in general practice on this. Is general practice saturated in various ways? Can a man get in at all? That is the thing, I think, you need.——*Sir James Paterson Ross*: That is why we hesitated to answer your question about the Willink Report. We do not really know that.—*Sir Harry Platt*: We do not.

4227. When we talked to the general practitioners they said it should be much easier to go from general practice to the hospital. When we talk to you you say it should be much easier to get from hospital into general practice.——I do not know that we gave the impression that there should be a barrier for the ambitious man in general practice to get out of it into the hospital field.

4228. *Sir David Hughes Parry*: You emphasised the difficulties.——The difficulties are very formidable.

4229. *Professor Jewkes*: They are technical?——Economical and technical.

4230. *Sir David Hughes Parry*: But when we talked to the other side they mentioned the difficulties in the other direction. *Professor Jewkes*: Economically and technically.——We recognise this impasse.

4231. *Sir Hugh Watson*: May we now turn to the question of merit awards with which Sir Harry is very familiar?——You have had a lot of evidence about it. As you know, it was a device to create the same range of remuneration throughout the age periods of consulting life that had been revealed to us. It was an ingenious idea of Sir Will Spens himself during one of the meetings and those of us who have had something to do with it feel that it has worked very well. There might be other systems if there had been time to devise a totally different framework but there it is: I can only say that so far it seems to be an equitable arrangement and it has worked reasonably well.

4232. *Chairman*: Do you prefer secrecy or not?——It depends what you mean by secrecy. In actual fact anyone who is a member of a Board of Governors or Regional Board knows that the original names were passed round the table. I well remember the first list which appeared at a committee of which I was chairman; I asked the members to forget about names as quickly as possible. That has been very honourably practised throughout by Boards. People forget about them. They are not entirely secret but they are not published in the journals, they are not published in any list.

4233. *Sir Hugh Watson*: And the general practitioners do not know about them, Sir Harry?——They know nothing at all about it as far as I know. I have never heard they were interested in it. —*Mr. Edwards*: I think it is tremendously important to keep these things as secret as possible, not to protect those who have got merit awards, but to protect those who have not got merit awards because it is a most invidious situation if you have a senior man in a hospital who has not got a merit award and it is known to his junior or other people that he has not got a merit award but his junior has. For that reason, and I think it is a conclusive reason, I believe it must be secret. It must be known to all the Governors.

4234. *Chairman*: Does that situation often arise?——Not infrequently by any means.

4235. *Sir David Hughes Parry*: I notice that Sir Harry did emphasise that it was not so much a merit award as a method of remuneration. That was the emphasis?——*Sir Harry Platt*: Yes, it was a method of creating a pattern, a salary pattern based on distinction or merit. It was assumed that a man who earned big fees as a consultant had something about him which was distinguished or meritorious just as at the Bar. It may be that that does not always work out, as you know, Sir David, but there it is.

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4236. *Chairman*: Has the College any suggestions as to how the system should be extended to embrace those engaged in general practice? We have all been devoting a lot of thought to that.——*Sir James Paterson Ross*: We were quite convinced it would be a good thing to do it but we are rather hoping the College of General Practitioners might think out the method and we rather left it to them. We have not actually given a lot of thought to it. We know ourselves there are some general practitioners who are more distinguished than others. We feel they should be rewarded for that because there is no other way of rewarding them but we think it should be done by the general practitioners.

4237. Does that mean that you do not think that the pure system of number of patients on lists is a good way of awarding merit?——I am quite sure it is not a good way.

4238. *Sir Hugh Watson*: I do not think I have any other questions I want to put, Sir James.

Now, Sir Wilfred Fish has not talked up till now. We have spent a great deal of time with Mr. Balding and his colleagues, we have had a great deal of information from them and I think we understand the problems confronting the general dental practitioner. We understand their sense of grievance with the way in which dental remuneration has been dealt with by the Government since the war. We have had some explanation from the Government about why it has been dealt with in that way and the whole matter is now under review. I do not know if you could help us about this: we know that the earnings of the average dentist depend on the number of treatments that he can put into his 33 chairside hours or whatever number of chairside hours a week he works and we know that these treatments have been worked out in point of time by the Penman working party. Would you think, Sir Wilfred, that these things ought to be reviewed from time to time in the light of the progress of knowledge and improvement in appliances and technique and so on, that the timings of dental operations ought to be periodically reviewed?——*Sir Wilfred Fish*: I think it would be wrong to say that our Faculty has considered that side of the problem at all and I do not think it would be right to express an opinion from the Faculty. If you were merely asking for a personal opinion on the matter that would be quite a different thing. Even so, I do not know that either of my colleagues would wish to comment on it. I do not feel in a position to comment on that myself. If you say do I think that the method of remuneration is the best that can be devised, and you ask me personally, I should be doubtful.

4239. Would you wish to suggest any other method, Sir Wilfred?——I would rather not, Sir, because all kinds of complications come in, but some of the points on which I am quite sure it would be fair to comment are these. It is wrong if, as we have been assured, though we do not know it of our own knowledge, the pattern of earnings of a dentist falls off as he gets older; that would hardly seem to be a reasonable state of affairs.

4240. We are given to understand that that is because owing to the extraordinarily tiring nature of his work a dentist, after he gets over a certain age, simply cannot put in so many operations in the course of the day.——There are other matters about it too. As a man gets older he has wider experience and ability and may prefer to do these things in a much better way, in a way he finds has advantages as his experience develops.

4241. *Chairman*: We understand this pattern existed before the Service and quite independent of it, that the dentists were at their peak earning in the earlier middle age.——I can discuss it for hours but I do not think it is appropriate to discuss it as a representative of the College. We have an enormous number of Licentiates of this College. Actually one-third of the profession today hold the L.D.S. of the College of Surgeons but the College is concerned with their examination and their post-graduate training, with providing them with a museum and library facilities and with carrying out research and it does not make a study of the conditions of remuneration in general practice.

We are much more concerned with the consultant aspect of the case and I think it would be quite wrong for me to express a personal opinion simply

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because I happen to be here. I do not know whether Sir William would care to comment on general practice. Neither of us has had any recent experience of it and Professor Bradlaw is in the same position because he has been a professor in the Durham University for a number of years. I do not know if he has any comment.

4242. *Sir Hugh Watson*: On that view may we take it that you regard yourselves as representing largely the dental consultants and that really the problems which confront you in your profession are very similar to those which confront Sir James in his profession?——Yes, very similar indeed, but we would just like to say that we would not for one moment have it thought that we are not concerned with the Licentiate who is not a consultant. We are very much concerned with his post-graduate education and with research that may help him but we are not concerned with his conditions of work, if I may put it that way.

4243. Or his remuneration?——Yes. But we have, as you know from our written evidence, some serious concern about the situation of the consultants and in particular about the shortage of consultant posts in the country in dentistry. That is a matter which we feel is extremely important.

4244. I suppose, Sir Wilfred, the shortage of consultant posts is a matter which depends upon the extent to which a need for consultants can be established? At least I am putting that the wrong way round but you see what I mean? ——Yes.

4245. Whose business is it to appoint consultants?——May I ask Sir William to deal with that?——*Sir William Kelsey Fry*: To take you into the history, we are a very young profession as compared with general surgery. Before the Health Service came in there were few dental consultants with a result that when the Health Service was introduced there were very few consultants made because there were very few men of consultant status; the rest were put on the hospital list as S.H.D.O. Now since the Health Service there is quite a considerable number of keen men who are taking higher degrees and are anxious to get into the Health Service, I think, more or less, on a full-time basis. It has been the function of the Faculty for the last ten years—and we have only been formed ten years—it has been our function to encourage men to work up for the consultant status. It is absolutely amazing to me that when we started ten years ago there were five men applying and now this term there are 60. There is an enormous influx of brilliant young men coming into the dental profession. These are the men with whom I mix and they are all men who are anxious to get into hospital service. But as we have already heard it is most frustrating to learn the length of time most of the senior registrars have to wait for appointment. I happen to know a Regional Board where there are 33 sessional places a week, that is three consultants to the whole of one Regional Board. If you could imagine a medical service without any specialists! But there is a tremendous need for consultant advice. You have heard about orthodontics; here are men thrown out into practice just qualified, doing specialist work without any consultant to advise them. I think there would be a great saving to everybody concerned if there were consultant posts in all the Regional Hospital Board areas.

4246. Whose business is it to appoint them?——The Regional Boards'. The Regional Boards are, as everybody knows, hard up for money and there are always expanding medical requirements. I will not say that dentistry has been a Cinderella but there is always difficulty in getting money. There was a time when University Grants earmarked grants to get money for dentistry. I seriously put it to the Commission that, in the same way as mental health where you have had to earmark money, I do not see any hope of getting a reasonable consultant service in this country without having money earmarked like that. Men are coming in, doing medicine, they are taking their Fellowship, they are going through the whole course. I admit they can go back into practice if they fail but they are all really dissatisfied men and unless we can get more consultant appointments the intake of these men is going to dry up.

4247. Sir William, there are two reasons why there should be consultants: one, that there ought to be a reasonable number of consultant posts to satisfy the ambitions of competitive senior registrars. But apart from that I understand

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that what you are telling the Commission is that there is need throughout the country for a large number of consultants in dentistry?——Not a large number, an adequate number. In the Region I mentioned we only have three for three million people. It seems fantastic. I am not asking for large numbers.

4248. *Chairman*: Three dental consultants?——Three full-time dental consultants to three million people.

4249. And some part-timers?——No. There were 33 half sessions, notional half days.—*Sir Wilfred Fish*: I think, Sir, there is a figure of one dental consultant to 300,000 of the population.—*Sir William Kelsey Fry*: That was what was suggested when the Health Service was started.—*Sir Wilfred Fish*: That is one of the earliest suggestions but it is some kind of yardstick.—*Sir William Kelsey Fry*: Professor Bradlaw may have some other figures.

4250. *Chairman*: According to Appendix A of the Health Departments' factual memorandum, there were 282 whole-time dental consultants in 1955, is that right?——*Professor Bradlaw*: May I help you. The latest figures are 772 consultant sessions in England and Wales in 1956. Those are the latest available figures.—*Sir William Kelsey Fry*: That includes all Universities, full-time professors at teaching hospitals.—*Sir Wilfred Fish*: A very large number of consultants only do one session or one or two sessions a week. That is not the whole-time equivalent of anything like 700 dental consultants and you must bear in mind in considering that that you are not dealing only with a single aspect of dental specialisation. You are dealing with orthodontists, surgeons, teachers and the like so that the situation which Sir William Kelsey Fry has represented in respect of his region is not only duplicated in other regions but by and large it is very much worse.

4251. On page 5 of the Ministry memorandum there is given a total of 676 part-time sessions plus, I suppose, 27 times eleven whole-time ones which made about 950.——*Professor Bradlaw*: Yes, Sir, the figures I have given you are the most recent figures available to the Ministry.

4252. Does that mean that your sessions include all the whole-timers?——Yes, Sir.

4253. *Professor Jewkes*: And when the Ministry of Health gives us statistics showing the number of dental consultants as 249 that means part-time and full-time?——Yes, Sir. It is possible to make available to you the break up of whole-time and part-time and show sessions done by part-timers but I would welcome an opportunity, Sir, if it is not too late, to say something on this problem from an entirely different aspect.

4254. *Chairman*: Yes, I think so. Some of the figures are a little bit confusing here but the general picture is not very much vitiated by that.——No, Sir. What I would like to address the Royal Commission's attention to is a different aspect of the matter altogether. It is not only a question of the unsatisfied needs in the regions. It is the effect on recruitment to the profession and the attitude of the members of the profession in consequence. You will appreciate, Sir, that a very substantial number of those on the Dentists Register who have dental qualifications have additional qualifications. I am speaking from memory, I have a figure of some 2,000 odd. Of the Board of the Faculty which we represent there is only a single man who has not got a medical qualification. I doubt very much if there are any staff on the London teaching hospitals, except one or two, who have not medical qualifications as well as higher dental qualifications.

If I may speak of Sir William Kelsey Fry and Sir Wilfred Fish, both of them, when they were younger men, have held medical appointments. Sir William has made perhaps the greatest contribution which has been made to oral surgery. Sir Wilfred Fish, a doctor of science, has contributed research which has altered our thinking. The point that I want to bring home to the Commission, if I may, is that unless there are opportunities for men of this calibre you will not only continue the frustration which exists now in the dental profession—as a dean of many years' standing I know this very well—but you will be turning away from the dental profession the very elements which we would wish to see entering a learned profes-

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sion on whose integrity, on whose scientific knowledge and whose maturity we must look for advancement and for co-operation with their medical colleagues.

Chairman: I think we have got that point.

4255. *Sir Hugh Watson*: Yes. In view of what Sir Wilfred Fish has explained about the functions of the body which he represents, they are very close in their interests to those of the side of the Royal College which Sir James represents. I do not think we can usefully pursue this matter further unless there is any matter you wish to develop, Sir William?——*Sir Wilfred Fish*: I agree from the general point of view, that has been our intention and ideal. It has, in fact, been our policy to ensure that dental consultants had a corresponding course of training to those in any other branch of surgery and, as you know, we give them approximately the same kind of course, the same number of years' training and they must take their Fellowship of the College in dental surgery.

4256. *Chairman*: And, Sir Wilfred, you do not in the consultancy branch have this same trouble about getting old too early, your earning power falling off after 35. You would not think you would be parallel to the medical profession there, would you, much more than in the general dental practitioners' branch?——You mean the dental consultant is not suffering from the diminishing of income as he gets older?

4257. Yes.——There are so few, if you mean in private practice.

4258. What I mean is that there is no reason why they should suffer the falling off to the same extent?——No, because they would become more competent and in private practice normally their fees would go up which is normal in private consultant practice;' as a man gets older he becomes better known. But, of course, in the Service it is purely a question of distinction awards, which are not reduced.

4259. At any rate salary does not fall off?——No.—*Professor Bradlaw*: If I might come in briefly, Sir, unfortunately private practice and domiciliary visits for dental consultants are so limited it would not make very much difference if their physical powers diminished.

4260. *Sir David Hughes Parry*: But the merit awards are there?——Yes, Sir.

4261. And they are not taken away once given?——No, Sir.

4262. *Chairman*: There was one point which arises from that for you, Sir James. Do the College consider that there is any case for a higher basic rate of salary for surgeons, for any particular group of surgeons or indeed any surgeons at all as compared with physicians or anyone else, or do you consider that all consultancies are the same? The latter, I think, has been the attitude hitherto. ——*Sir James Paterson Ross*: I think, Sir, that has been accepted.

4263. It has been put to us by one branch of surgeons that there ought to be something special for them.——I have never heard that put forward. I must say I have never thought of it. Of course it is interesting that the consultants generally have been made equal as far as their salaries are concerned in the Health Service whereas certain branches—we are speaking in committee now—for example anaesthetists, I think, in the past got smaller fees than surgeons did and therefore they have had a relative increase in salary. I think I am right in saying that, am I not? But as regards one branch of surgery and another branch of surgery I would not have thought there was any ground.—*Sir Harry Platt*: I think as a College we really could not support that idea. Personally the idea of rewarding the exceptions—this is my own personal opinion—of certain super scale payments to attract to certain positions a man, say, from Canada or the United States, might have something in it. But to say that a thoracic or heart surgeon or neurosurgeon, long hours and so on, I know the argument, demands more than surgeons in other fields, I do not think we could support that at all. We are not really claiming that the surgeon should be better paid than the physician. The merit award has made that difference between all consultants that some are more equal than others.

4264. *Professor Jewkes*: But you are suggesting that the earnings of a consultant in some of these other countries, United States, and so on, are so much higher than they are here that if we are ever going to get these people to come across we have to have a higher limit?

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——That is my own personal view for certain very important fields.—*Sir James Paterson Ross*: For appointments rather than for a class of specialists.—*Sir Harry Platt*: If you want to get a man as in the United States you have to offer him more.

4265. *Chairman*: You want these special awards attaching to posts?—— We are not recommending that as a College. We have discussed it and our Council was not unanimous, Sir.

4266. I hope you do not think we have questioned you insufficiently, Sir William and Sir Wilfred, by devoting such a short time to the special problems of dentistry but I do not think there are any other questions we have on that subject.—— *Sir Wilfred Fish*: We are only concerned that our consultant branch should develop. When Sir William says we are a young profession I was thinking of the early days in dentistry: we are just about to celebrate our centenary in the College of Surgeons. We are not as young as all that but we are a small profession and it is very important certainly that the consultant branch should be developed and not be stinted in the number of appointments that are made either for the welfare of the people's health directly—because they do need consultant treatment—or for the welfare of the profession where they can only have one object and that is to give the public better treatment. Therefore I think on both grounds it is very important that there should be an increase in the number of consultant posts and for our part we will undertake to see that our consultants are well trained and deserve any encouragement they are given.

Chairman: I think that ooncludes this session. Thank you very much.

(*The witnesses withdrew*)

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

SEVENTEENTH DAY

Friday, 25th April, 1958

Present

SIR HARRY PILKINGTON (*Chairman*)

MR. J. H. GUNLAKE, C.B.E., F.I.A., F.S.S.
SIR DAVID HUGHES PARRY, Q.C.
SIR HUGH WATSON, D.K.S.
MR. I. D. MCINTOSH, M.A.

MR. W. A. FULLER, D.S.C. (*Secretary*)
MR. J. B. HUME (*Assistant Secretary*)

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

Memorandum of Evidence to the Royal Commission on Doctors' and Dentists' Remuneration

The objects of the Royal College of Obstetricians and Gynæcologists, as declared by its Royal Charter, are "the encouragement of the study and the improvement of the practice of obstetrics and gynæcology, subjects which should be inseparably interwoven".

The affairs of the College are governed by an elected Council, which itself elects the President, Vice-Presidents, Honorary Treasurer and Honorary Secretary. London, England and Wales, Scotland, Northern Ireland, Eire, are represented on a geographical basis by a specified number of Councillors.

. . . . . .

The Council of the College is precluded by the terms of its charter "from engaging in any transaction with a view to the pecuniary profit or gain of the individual members thereof". For this reason it cannot make detailed recommendations on rates of pay.

It wishes, however, to draw the attention of the Royal Commission to two important points:—

(i) It is of the greatest value to the patient that obstetrics and gynæcology should be practised together as one subject at consultant level, thus forming, with medicine and surgery, the three branches of modern medicine.

(ii) Due consideration should be given to the fact that the practice of obstetrics makes extra demands on those who undertake it. The amount of emergency work, especially by night, which cannot easily be delegated by reason of its character, is far higher than in any other branch of medicine.

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If the statements made above, which Council believes are important for the well-being of the service, were generally accepted and implemented in practice, it would still follow that for an interim period there would be certain specialists practising obstetrics only and paid at a lower rate than those of their colleagues who combined obstetrics with gynæcology and held consultant (as opposed to S.H.M.O.) posts. The Council believes that all hospital obstetric beds should be under the control of consultant obstetricians and gynæcologists.

The Council of the Royal College of Obstetricians and Gynæcologists agrees in the main with the statement prepared by the Joint Consultants Committee and with Part I of the evidence submitted by the Royal College of Physicians. It has not yet had an opportunity of considering any further evidence submitted by the Royal College of Physicians, the Royal College of Surgeons or other bodies.

With these general observations, the Council would make the following comments on the document submitted by the Royal Commission. There are certain questions, particularly some relating to general practice, on which Council felt it was not in a position to make worthwhile comment. For this reason no answer has been given to questions (vii) (a) and (b), (ix), (xi), (xiv), (xvi), (xix), (xxi).

The following observations are made on the remaining questions asked by the Royal Commission.

(i) *The quality and quantity of recruits*

This is a matter on which the universities, undergraduate medical schools and pre-clinical training units are best able to speak. It is not until their pre-registration year at the earliest that these recruits come to the notice of the College.

(ii) *The quantity and quality of newly qualified doctors*

It would appear that there is a sufficient number of qualified doctors to fill the obstetric and gynæcological house posts. The Royal College of Obstetricians and Gynæcologists has no evidence to suggest that the standard of academic achievement of the newly qualified doctors is deficient, yet knows that there has been a change in the type of person taking up medicine as a career. There are fewer young doctors drawn from professional classes and particularly from doctors' homes. While this is not a bad thing, *ipso facto*, Council believes that it indicates that the professional classes regard medicine as a less satisfactory career than previously and if this is so, it should be viewed with misgiving as the tradition of service and sense of vocation so essential to the practice of medicine at its highest level, are less easily acquired by those brought up in homes without this background.

(iii) *Wastage of men and women during training and in the first few years after qualification*

This appears to be minimal in obstetrics and gynæcology. Relatively few who start their training in these subjects abandon it for specialisation in other branches of medicine.

(iv) *The cost and duration of training*

The requirements of the Royal College are confined to postgraduate training and are outlined in the regulations. At present a minimum of three years residence in approved hospitals is necessary for candidates for the Membership but this may be increased. Candidates for the Diploma in Obstetrics (a general practitioner's and not a consultant's qualification) are required to hold a six months resident appointment in that subject, again in an approved hospital. It is the opinion of the College that every general practitioner practising obstetrics should have held a resident postgraduate appointment in obstetrics.

All the posts referred to above are paid posts. The Council would not consider that there was a case for supplementary grants except under very exceptional circumstances, which would be more likely to apply at registrar level. It occasionally happens that a post in obstetrics and gynæcology, or in another closely

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allied branch, *e.g.*, pathology, biochemistry or endocrinology, in a good teaching unit would be of great advantage to a trainee already moderately senior. His commitments and responsibilities might be such that he would be unable to meet his financial obligations on the salary for a junior post, and be forced by circumstance to take a registrar post under conditions less favourable for his training. It would be an advantage under such special circumstances, which admittedly are rare, if a grant could be made available to assist in the training programme.

(v) *The position and prospects of a newly qualified doctor*

The College submitted a memorandum relevant to this question, to the Willink Committee in July, 1955, a copy of which is appended.

(vi) *Any trend to excessive resort to certain branches of the profession*

The College has no evidence to suggest that there is in relation to the other branches of medicine an excessive number of specialists in training today in obstetrics and gynæcology. The number is probably influenced by the exacting demands of this type of practice.

(vii) (*c*) *The relative advantages and disadvantages of a whole-time consultant in the National Health Service*

The grades referred to in questions (*c*) to (*f*) inclusive are grades in which the College is interested. The whole-time consultant has many disadvantages under the present arrangements. It is impossible for him to fulfil his duties unless he has a 24-hour telephone service in his home, and a car available night and day—yet he obtains no tax relief at present on these essential items. Membership of learned societies, and the study of scientific journals are an important need of a practising consultant. Council feels that the expense incurred in connection with all the above, should be allowed for income tax purposes.

It is in the interest of both patients and consultants that there should be an opportunity for private practice. Whilst it is admitted that facilities exist, the cost to the patient is often prohibitive, even though in some instances offset by contributory insurance schemes. These do not, however, contribute to expenses for normal midwifery. Thus, beds are occupied by many patients who are able, and would prefer, to make a contribution for the satisfaction of being a private patient under the clinical care of the doctor of their choice, but who are unable to pay the high hospital charges now demanded. An extension of private bed accommodation with a reduction in the costs—in recognition of the fact that patients occupying such accommodation are not claiming accommodation under section (iv) or (iii) to which their National Health Service contributions entitle them—would result in an increased income to the exchequer and the consultant.

If increased private bed accommodation were provided it might well result in fewer consultants having a maximum number of sessions and more with a reduced number. The Council considers that a hospital is better served by two or more consultants with fewer sessions than by perhaps only one consultant with a maximum number of sessions. Because of the exacting demands of obstetric practice it is humanly impossible for one consultant to be constantly on duty day and night. There must therefore be more than one consultant available in a given area if there is to be adequate specialist cover for holidays, illness and absence from other causes, quite apart from the demands of the day to day control of the obstetric and gynæcological service. This is particularly important in scattered areas, but without means of securing a full income, that is by private practice, such an arrangement is impracticable.

(viii) *The difficulties encountered by members of the Registrar grades*

The present system of staffing hospitals is dependent to a great extent on registrars, particularly of the Senior Grades, whose posts are regarded as training for consultant responsibilities and practice. With the limited number of consultant posts all registrars cannot hope to achieve consultant status and at the end

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of the profession in the future, and the consequential intake of medical students required."

The report is based on conditions appertaining at the present time: no attempt has been made to anticipate changed conditions.

The present position

In order to discover how many practitioners are engaged in obstetric and gynæcological practice in all grades in the National Health Service in England, Scotland and Wales, the College has prepared a questionnaire for Boards of Governors and Regional Hospital Boards, the correlated replies to which are given in Appendix A. The College has also obtained statistics from the Ministry of Health and the Department of Health for Scotland. These statistics, together with other information, were published in the British Medical Journal Supplement 26/2/55 p. 66, and these are given in Appendix B.

From the answers to the questionnaire it seems that there is a total number of 708 Consultants and S.H.M.O.s employed in England, Scotland and Wales (not including 9 vacancies in establishment or a required increase in establishment of 13). But in the B.M.J. Supplement the total number, obtained from the Ministry of Health, was given as 580. The difference of 128 may be due to Consultants working for more than one Hospital Board and therefore being included in answers to the questionnaire by more than one Board. For this reason the total number of Consultants and S.H.M.O.s is assumed in this memorandum to be 580. Since Senior Registrars, Registrars and House Officers are not usually employed by more than one Hospital Board the figures relating to these appointments in the questionnaire are considered to be correct. In the following totals vacancies in establishment are included, but required increases in establishment are stated separately. In accordance with the opinion of the Council of the College that the posts at present filled by S.H.M.O.s should in fact be filled by Consultants, the two appointments have been considered together.

The present position in England, Scotland and Wales can be summarised as follows:—

(*a*) *Consultants and S.H.M.O.s.*

Total number 580.

(In the replies to the questionnaire there were 623 Consultants and 94 S.H.M.O.s, including 9 vacancies in establishment. Of the Consultants, 526 were part-time with an average of 6 sessions each. There was an increase in establishment required of 13 Consultants and no S.H.M.O.s.)

(*b*) *Senior Registrars.*

Total number: 115 (including 5 vacancies in establishment).

These are distributed as follows:—

1st year	36
2nd year	22
3rd year	14
4th year	14
5th year or supernumerary or transitional	29

(In addition there was an increase in establishment required of 3 Senior Registrars. The above statistics do not take into account those who have finished their consultant training but who have no appointment. There is no way of estimating their number.)

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(*c*) *Registrars.*

Total number: 232 (including 20 vacancies in establishment).

These are distributed as follows:—

1st year	111
2nd year	121

(In addition there was an increase in establishment required of 8 Registrars.)

(*d*) *Senior House Officers and House Surgeons, Registered and Pre-registration.*

Total number: 669 (including 16 vacancies in establishment).

These are distributed as follows:—

Senior House Officers	176
Registered House Surgeons	153
Pre-registration House Surgeons	340

(In addition there was an increase in establishment required of 6 Senior House Officers, 2 Registered House Surgeons and 1 Pre-registration House Surgeon.)

The Service Provided at Present.

As shown in Appendix B there are 19,924 obstetric and 10,443 gynæcological beds in England, Scotland and Wales.

From this it can be worked out that there is:—

1 Consultant or S.H.M.O. for every 34·5 obstetric beds and every 18 gynæcological beds.

1 Senior Registrar or Registrar for every 57·5 obstetric beds and every 30 gynæcological beds.

1 Senior House Officer or House Surgeon for every 30 obstetric beds and every 15·5 gynæcological beds.

The Training of Consultants at Present.

If the average length of service as a Consultant is 30 years there will be an average of 19·3 consultant posts vacant annually through retirement. In Appendix B it is anticipated that between 1963 and 1974, the average number of Consultants and S.H.M.O.s retiring each year will be 20. At the present rate there will be an average of 23 Senior Registrars, 116 Registrars and 1,162 Senior House Officers or House Surgeons finishing their appointments each year. Thus for every Senior Registrar who completes his training there are 5 trained as Registrar and 50 trained as Senior House Officer or House Surgeon.

The future position

At the present time 65 per cent. of births are institutional (see Appendix B). It is the policy of the College that there should be beds available in hospital for every expectant mother who needs or wishes to be confined in hospital. It is anticipated that the total number of institutional births might increase to 90 per cent. Nevertheless it is probable that this increase will be mainly in General Practitioner Maternity beds which means that little addition to the number of obstetricians in training will be needed, because these beds will be staffed by General Practitioner-Obstetricians who will be able to admit abnormal cases to an associated Hospital Maternity Department, in which there are already beds available for such emergencies.

It is assumed, moreover, that the proportion of part-time and full-time Consultants will remain the same as at present.

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Thus if the requirements for increases in present establishment are taken into account the future needs will be:—

(*a*) *To run the Service.*

Consultants	600
Senior Registrars	120
Registrars	240
Senior House Officers	180
Registered House Surgeons	155
Pre-registration House Surgeons	340

Thus, as a rough guide, there will be:—

1 Consultant for every 35 obstetric and 20 gynæcological beds.

1 Senior Registrar or Registrar for every 55 obstetric and 30 gynæcological beds.

1 Senior House Officer or House Surgeon for every 30 obstetric and 15 gynæcological beds.

It is suggested that if there is an increase in the number of Consultant Hospital Beds, in those areas in which there is at present a shortage, there should be a corresponding increase in personnel although the general ratio suggested above may not be applicable to all hospitals, for the individual requirements vary with the type of work carried out.

(*b*) *To train Consultants.*

If there are 20 Consultants reaching the age of retirement each year there should be 25 Senior Registrars fully trained annually to fill the vacant consultant posts and to allow for those who go abroad or take up academic posts or go into another branch of medicine.

If the training of a Senior Registrar is for five years this means a total at any one time of 125 Senior Registrars. But in order to run the Service nearly three times as many Senior Registrars *and* Registrars will be needed. It is suggested therefore that approximately 250 Registrars are trained at any one time of whom only one in five will be selected to proceed to Senior Registrar to train as a Consultant, *i.e.*, 125 new Registrars each year. This means that selection as a Senior Registrar almost ensures a Consultant post when the training is complete.

If, on the other hand, it is considered that the training of a Senior Registrar is complete at the end of four years (instead of five years) a total of 100 Senior Registrars will be needed to replace Consultants at the rate of 20 a year. But in order to run the Obstetric Service a total of 360 Senior Registrars *and* Registrars will be needed and therefore there will have to be 260 Registrars at any one time, or 130 new Registrars appointed each year, of whom about one in five will continue to specialise in Obstetrics as a Senior Registrar.

Because of the importance of their training it is suggested that Senior Registrars should be trained partly in a teaching hospital. In many instances this will probably be in joint appointments with Regional Hospital Boards.

It is realised that there should be a few additional Registrar and Senior Registrar posts for the training of men from the Dominions who will presumably return there when their training is completed.

There are at present approximately 345 Pre-registration House Surgeons and 155 Registered House Surgeons being employed at any one time. Since these appointments are each for six months it means that approximately 1,000 Pre-registration and Registered House Surgeons will be trained in Obstetrics and Gynæcology (or both in combined appointments) each year. This figure represents the number of students required to fill these posts annually. They will presumably also undertake other House appointments in the various branches of Medicine and Surgery before or after undertaking an appointment in Obstetrics or Gynæcology. From this number will be those who are to become Senior House Officers (at

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the rate of 180 each year), Registrars (at the rate of 125 each year), Senior Registrars (at the rate of 25 each year) and, finally, Consultants (at the rate of 20 each year).

Thus it can be worked out that to replace a Consultant and to run the Service on the present system it will be necessary to train at the same time 1·25 Senior Registrars, 6 Registrars and 60 House Officers.

The above estimate assumes that the pattern of hospital staffing remains as it is at present and makes no allowance for the time occupied in National Service.

Signed on behalf of the Council of the Royal College of Obstetricians and Gynæcologists,

A. A. GEMMELL,
President.

July, 1955.

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DETAILS OF OBSTETRICAL AND GYNÆCOLOGICAL PERSONNEL IN THE SERVICE OF BOARDS OF GOVERNORS AND REGIONAL HOSPITAL BOARDS

(Including all doing Obstetrics, Gynæcology or both)

	Present Establishment			Vacancies in Establishment	Increase Required in Establishment			Due to retire within five years
	Whole-time	Part-time	Total No. of sessions		Whole-time	Part-time	Total No. of sessions	
CONSULTANTS	67	478	2,771	5	6	7	62	56

	Present Establishment	Vacancies in Establishment	Increase Required in Establishment	Due to retire within five years
S.H.M.O.	78	—	—	4
SENIOR REGISTRAR 5th year or supernumerary or transitional	22	—	—	
4th year	7½ YY	1	—	YY ½ joint appointment with Welsh R.H.B.
3rd year	13	—	2	Manchester R.H.B. and United Manchester Hospital's 3 consultants overlap.
2nd year	20	—	—	
1st year	25	1	1	
REGISTRAR 2nd year	108	4	5	
1st year	86	13	3	
S.H.O....	157	2	5	
HOUSE SURGEON Registered	137	1	2	
Pre-registration	300	11	1	

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SCOTLAND

APPENDIX A (2)

DETAILS OF OBSTETRICAL AND GYNÆCOLOGICAL PERSONNEL IN THE SERVICE OF BOARDS OF GOVERNORS AND REGIONAL HOSPITAL BOARDS

(Including all doing Obstetrics, Gynæcology or both)

	Present Establishment			Vacancies in Establishment	Increase Required in Establishment			Due to retire within five years
	Whole-time	Part-time	Total No. of Sessions		Whole-time	Part-time	Total No. of Sessions	
CONSULTANTS.....	23	48	384	2P/T	—	—	—	4
S.H.M.O.	14	—	—	2	—	—	—	2
SENIOR REGISTRAR								
5th year or supernumerary or transitional	7	—	—	—	—	—	—	—
4th year	5	—	—	—	—	—	—	—
3rd year	1	—	—	—	—	—	—	—
2nd year	2	—	—	—	—	—	—	—
1st year	7	—	—	3	—	—	—	—
REGISTRAR								
2nd year	8	—	—	1	—	—	—	—
1st year	10	—	—	2	—	—	—	—
S.H.O.....	16	—	—	1	1	—	—	—
H. SURGEON								
Registered	14	—	—	1	—	—	—	—
Pre-registration	29	—	—	—	—	—	—	—

(*May, 1955*)

APPENDIX B

June, 1955.

Information received from the Ministry of Health and the Department of Health for Scotland regarding evidence to be submitted to the Willink Committee.

	England & Wales	*Scotland*
Obstetric Beds	17,171	2,753
G.P. Maternity Beds	2,449	423
Total Births	690,823	94,714
% Institutional	64·3	70
Gynæcological Beds	9,118	1,325

British Medical Journal Supplement—26/2/55 *p.* 66.

OBSTETRICIANS AND GYNÆCOLOGISTS

Total Consultants and S.H.M.Os in Great Britain (*i.e.*, England, Scotland and Wales) 580—(England and Wales 413 Consultants and 87 S.H.M.O.s—separate figures for Scotland not available).

Between 1963-74 the average number of Consultants reaching age 65 each year is 20—before 1963 the number is less.

Total Senior Registrars in Great Britain (*i.e.*, England, Scotland and Wales) is 71:—

1st year	26
2nd year	15
3rd year	17
4th year	13

There are however a number of additional people at this level.

Examination of Witnesses

PROFESSOR A. M. CLAYE, *President*
MR. T. L. T. LEWIS
MR. H. J. MALKIN
MR. J. H. PEEL

on behalf of the Royal College of Obstetricians and Gynaecologists
Called and Examined

4267. *Chairman*: Professor Claye, we have had your memorandum, which we have read with much interest. You probably know that we have already seen your sister Colleges, the Physicians and the Surgeons, and we have also seen the Colleges in Scotland, so that we have covered fairly fully by now a good many of the points of general interest to the Colleges, and we may not need to go into all of them in great detail with you. We hope, therefore, that we shall be able to ask you all the questions we wish to, before lunch today, and that we may finish by then. You will know that this is a public hearing and, therefore, if there are any things you do not want to be published,

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you had better not say them. Once yesterday somebody said "Since we are in Committee, I will say such-and-such", but we are not. Anything that is said is liable to be reported. If we press you fairly thoroughly on some of the representations you have made, please do not interpret that as meaning either disbelief or hostility. Equally, do not interpret the fact that we do not ask you about some points as meaning that we think they are irrelevant, or that we accept them; it is just for us to make up our minds on them, in due course.

We have got two eminent lawyers on this Royal Commission, who have done most of the work in going through the submissions and getting an orderly way of approaching our questions, and in this case Sir David Hughes Parry, whom you may already know, is going to take the lead in asking most of the questions. But you will be asked questions by anybody on the Commission, and in your turn I hope you will feel free to let any of your colleagues reply on any subjects that you think are more particularly up their street. We want to get the best of this opportunity.——*Professor Claye*: Yes, Sir.

4268. *Sir David Hughes Parry*: May I say before I begin that, if there is any matter which you would like to add to what you have already said to us, I hope you will take the opportunity when we deal with the different paragraphs?——Yes, I will do that.

4269. Or, if there is any alteration or modification you wish to make there will be every opportunity, and I hope you will take it. Could we begin on the first page? Your paragraph (ii) says:

> "Due consideration should be given to the fact that the practice of obstetrics makes extra demands on those who undertake it. The amount of emergency work, especially by night, which cannot easily be delegated by reason of its character, is far higher than in any other branch of medicine."

I wonder if you have any particulars that would help us to see the problem, in the form of statistics, of the number of times a consultant may be called out at night? We have a general impression that the general practitioner and, perhaps, even the consultant, is not called out now as frequently at night as formerly.——Yes. I think that is true, Sir, but we have not got any definite statistical evidence about this. But I think it is the belief of our Council that, even so, both the consultant and the general practitioner get more calls in this branch, than in others.

4270. But it is a general impression? ——We have not got chapter and verse for you.

4271. *Chairman*: When you say that due consideration should be given, what does "due consideration" mean? Are you implying that this particular speciality should be rather better rewarded than other specialties, on account of these extra claims?——I think that this sentence applies more particularly to the general practitioner, Sir, and if the general practitioner has a lot of emergency obstetric work, then he needs the time to do that, and has less time to devote to other work; some sort of adjustment should be made because of that.

4272. *Sir David Hughes Parry*: On page 910, I think you just state that it would be better for us to treat with the Universities and the medical schools, on the question of the quality and quantity of recruits, but in the following paragraph, on the quantity and quality of newly qualified doctors, you say "There are fewer young doctors drawn from professional classes and partioularly from doctors' homes", and you believe that this indicates "that the professional classes regard medicine as a less satisfactory career than previously . . ." I wonder if that is an impression. There are many things that contribute to this factor, are there not? I wondered whether this did follow logically.——Yes, I think there are a great many doctors who would have encouraged their sons to go in for medicine, who now try to dissuade them.

4273. Why?——I think that the uncertainty of a good living is greater than it was.

4274. You do not mean to say that they are going into other professions, where they are adequately paid by salary?——No, I do not think so—not exactly, Sir. There is less enthusiasm, I would say, in doctors' households for the profession of medicine, for a great many different reasons, and therefore they do not encourage their sons to the

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extent that they did to go into the profession.

4275. But it may well be that there is a call from other vocations, scientific vocations for example. It may be that.——Yes. That is not our point. Our point is that the fathers, themselves, dissuade them because they are not happy about the present set-up of medicine.

4276. *Chairman*: Your College, to a greater extent than the others, I think, covers the Commonwealth as a whole, does it not?——Yes, Sir.

4277. So you might, perhaps, be in a position to say whether this tendency is universal or widespread in many countries.——No. The countries of the Commonwealth that I know best are Australia and New Zealand, particularly Australia, where the arrangement is quite different.

4278. Yes, but by the word "tendency" I mean the tendency to encourage their sons to go into other things, because it has appeared to us that, for instance, there is a very parallel tendency in the United States. I thought that perhaps you, in your College particularly, could give us a few facts as to whether the tendency for doctors' sons not to become doctors is much more marked here than elsewhere, or not.—No, I am afraid I have not got any definite evidence about that, Sir.

4279. Do you think your College would be able to get any, because this is a point that you are rather making, and it is particularly valid if it only applies in this country.——Yes, I have no doubt we could make enquiries and find out. My impression as regards Australia is that the doctors are very happy with their set-up. I heard that time and again.

4280. *Sir David Hughes Parry*: This matter has been suggested to us in other vocations, and we are trying to find out why it is that parents in the medical profession do not encourage their children, if that is so, to take up the career of medicine. It may be that the parents are after a greater measure of security for their children in salaried professions; it may be that the competition of other professions is much greater, and that it is easier now for these young people to get into these professions which are greater in number; it may be that it has been found to be very difficult to get admission to medical schools—that is a possibility, is it not—and, therefore, many are not encouraged to go in now, because of that difficulty; and it may be that the parents are in an income group where they do not get grants to help their children through University. All these things, obviously, have an effect, as well as those you have suggested, do they not?——On the question of grants, I think that is an important point.

4281. But you agree as to the others?——I wonder if you could just recapitulate briefly.

4282. The first one we have already mentioned. You are not quite certain about that, whether the parents advise their children to go into a more secure profession, whether there is competition from other professions?——Yes, that may well be.

4283. And difficulty of admission to medical schools.——Yes, that was the point I wanted to take up, because I do not really think there is much difficulty about admission to medical schools. The figures that you get are swollen, because so many people apply for several different medical schools and, in fact—certainly in the provinces—we have very little choice with our vacancies about accepting people. I do not know if any of my colleagues would like to make any comment on this.

4284. *Chairman*: Which part of the provinces do you belong to, Professor Claye?——Leeds.

4285. *Sir David Hughes Parry*: That is the impression we also got from Scotland, but it is another impression that I have from London.——Yes, I think that may well be. Two of my colleagues are from London, and are better qualified to answer that than I am.—*Mr. Peel*: I would say that, as far as that is concerned, there is no shortage of applicants to become medical students. And I think there is no great difficulty in choosing suitable candidates. I would agree that it is not all that difficult for a suitable boy to become a medical student. I think that is a fact throughout the country.

4286. *Chairman*: You mentioned "a suitable boy". In Scotland, particularly, we were also told that they were able to exercise rather more selection, if I

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remember rightly, with boys than girls, but at any rate the question of girls was quite material.——Yes, I think it is true to say that the medical schools have a fairly fixed quota of the two sexes, and I would say that it probably is more difficult for a girl to take up medicine, than for a boy, and to get a place in a medical school.

4287. *Sir David Hughes Parry*: Who has fixed the number or percentage for the women?——I think that is fixed by the University of London. That is my recollection. At any rate, it is by agreement amongst the various constituent parts of the University.

4288. I thought that the agreement on the University side was that the medical schools should reserve not less than 20 per cent. of their places for women. I think it is left to the medical schools, themselves, to say how many they will take, and I think it may very well be that the medical schools among themselves have reached agreement.——Yes, I think that is quite true.

4289. *Chairman*: Are you feeling that parents are less willing than before to advise their daughters, as well as their sons, to take up either medicine as a whole, or your particular branch of the profession, or is it particularly sons?—— *Professor Claye*: I would have thought particularly sons, Sir.

4290. *Sir Hugh Watson*: Whilst giving a certain amount of weight to the various considerations that Sir David has just put before you, Professor, I gather from what you say that your view still is that the principal factor in this matter is the fact that doctors are actively dissuading their sons from following in their fathers' footsteps.——Yes, I think that is so.

4291. Could you tell us exactly for what reasons you think doctors are doing that, because if it is something to do with remuneration, we are here to advise about remuneration, and we would like to know about it.——Yes, I think remuneration has a good deal to do with it, Sir.

4292. From what point of view?—— That now, as compared with before the advent of the Health Service, the status of the doctor, financially, is not so good as it was.

4293. That applies to almost all the professions, does it not, Professor?—— I suppose it does, yes.

Sir Hugh Watson: I think Sir David and I feel it applies to us.

4294. *Chairman*: And you feel that applies to the general practice branch, as well as the hospital branch?——Yes, I would say so, from the people I have spoken to, Sir.

4295. *Sir Hugh Watson*: Do you feel, Professor—I think this is a matter of some importance—that this is because the level of remuneration of doctors has not been brought up in accordance, roughly, with the standard of living, or is it deeper than that, or what is it? ——I think it is partly that, and, of course, you know there is bad feeling on the subject of Spens. The doctors do feel that they have not had a square deal on that, and that no doubt is one thing which will tend to make parents dissuade their sons from going in.

4296. *Chairman*: How long has this dissuasion been going on?——I would say for several years, Sir.

4297. The bad feeling is of more recent growth, is it not, as regards the question of Spens?——Yes.

4298. *Sir Hugh Watson*: There could be no doubt that, at least until 1951, everything was all right, because that was the year in which Mr. Justice Danckwerts pronounced his award, which I think it is fair to say is regarded as not ungenerous by the medical profession.—— Yes.

4299. It is also fair to say that the medical profession, themselves, made no claim after that until 1956, as I understand it. So all this bad feeling has arisen since the claim was put forward by the British Medical Association in 1956? Is that right?——I think very largely, at any rate.

4300. I do not want to appear to be cross-examining you or tying you down, but that is only two years ago, you see, and after all this Commission was set up 13 months ago, not so very long after the B.M.A. began to prosecute their claim. You told the Chairman just now that doctors had been dissuading their sons for several years, and I think it is most important that the Commission

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should really have some idea why they have been doing that. I know they have, but I would like to know why.——Yes. I think it is true that the profession did not start taking action on remuneration at once. They have a certain amount of feeling that everybody is in this, and they delayed until 1956 because of that, but I think there was some ill-feeling before then.—*Mr. Malkin*: Could I mention two points, Sir? I think there was a little more dissatisfaction among consultants about the interpretation of Spens than among general practitioners in 1952. It was mainly the general practitioners who benefited from the Danckwerts Award. There was a slight adjustment for consultants, afterwards.

4301. In 1954?——Yes.

4302. *Chairman*: That was an adjustment that Sir Russell Brain said restored the balance between the two branches of the profession.——Yes, Sir. It was not viewed quite as satisfactorily by the consultants. Another point, which I think worries a consultant, is the diminishing private practice which obviously affects his remuneration very much, and a lot of us think that the cause of the diminishing private practice is the fact that the patient has to pay so much for private accommodation if he or she wishes to have private treatment.

4303. We will come to that later in your memorandum.——Yes, I appreciate that, Sir, but it is one of the causes arising from the question that Sir Hugh Watson has put about a certain amount of dissatisfaction, and the tendency for doctors not to encourage their sons to follow in their footsteps.

4304. One is bound to take the discouragement or encouragement into the profession as a whole, and not particularly your branch, or the consultancy branch. In your paragraph (vi) you say that there is no evidence to suggest an excessive number of specialists in training today in obstetrics and gynaecology, but I rather gathered that you did not think there was any excessive resort to any particular branch. I rather deduced that from that answer.——Yes, that is so, but our families will see us as their model, and our reaction is that they will go by our experience in making their decisions as to whether they will go into medicine as a whole.

4305. *Sir Hugh Watson*: This pull away from the professions is not confined to medicine, Professor Claye. There are many reasons why young men are not going into any of the learned professions in the numbers or the proportions which they used to, and Sir David has said some of the reasons. Would you agree that, perhaps, the young man today has more say in this, than he used to have when you and I were younger?——*Professor Claye*: Yes.—*Mr. Peel*: I think it would be reasonable to say on this pull away from medicine that remuneration is only one of the factors.

4306. That is what I wanted to get at. What other factors do you look to?——They not only concern remuneration, but they concern the whole structure of medicine, and the change which has taken place since the introduction of the National Health Service. There are inevitably factors of change between before and after the National Health Service.

4307. Which make the practice of medicine less attractive?——Which make the practice of medicine less attractive.

4308. *Chairman*: That is one reason why I was very much hoping for some factual information from your College, as well as an impression—some factual information about the other parts of the world, with which you deal, where conditions are quite different. I think your College ought to be particularly well-placed to give us some facts on that.——*Professor Claye*: We will think about that.—*Mr. Lewis*: May I raise one point about security? I think it was suggested by Sir David that, perhaps, more secure professions were attracting the sons of doctors. I do not know whether Professor Claye meant it, but I think he implied that, perhaps, more secure professions were attracting the sons of doctors. I think that the impression among doctors is that the profession is if anything more secure now, but at the same time the restrictions are more and the rewards, as has been said, are less. But on the point of security, I would have said that medicine is as secure for a young man to go into, as any other profession.

4309. *Sir David Hughes Parry*: May we move to paragraph (iv) on the cost and duration of training? There are two matters I would like to raise on that. You say "At present a minimum of three years residence in approved hospitals is necessary for candidates for

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the Membership but this may be increased." Is there any further information on that?——*Professor Claye*: The College is considering this very question at the moment. As you have said, we are a Commonwealth College and we have agreed a draft here, which has now been sent out to our regional councils in the Dominions, for approval. That will involve an increase in the length of training, if it goes through.

4310. And an increase in the cost? It essentially involves that, does it not?——Yes. Of course, they are in paid posts all the time.

4311. But that is the action of the College? It is the College itself which is increasing the length of the training and increasing the cost?——Yes. These young men are in paid posts all the time they are training. We hope they will be more effective gynaecologists when they have finished it, than they are now. That is our view.

4312. The other matter arises later on in that paragraph, where you say "It is the opinion of the College that every general practitioner practising obstetrics should have held a resident postgraduate appointment in obstetrics." At present, the man who is doing his year of intern or pre-registration clinical work has got to spend one year—six months in medicine, and six months in surgery—has he not? That is the present position?——Yes, but this is very broadly interpreted. Obstetrics is regarded by the General Medical Council as either medicine or surgery, as convenient.

4313. You were not contemplating that the one year should be extended to 18 months? That is all I am asking.——There is nothing fixed about that, Sir. Actually, we should be very glad if the obstetric appointment could be done after the pre-registration year, because we think a man is in a better position to profit by it then. The General Medical Council tells us that there are not enough general posts for the available recent graduates, unless some obstetric posts are included, so that it is still true that a great many obstetric posts are pre-registration posts.

4314. And you really are recommending that no-one should go into this kind of practice as a general practitioner, without the six months training?——We do not want a general practitioner to practise obstetrics, unless he has done this appointment after graduation.

4315. You do not go any further than that? As far as the general practitioner is concerned, you do not ask for any special qualifications, other than the six months?——No. As you no doubt are aware, we give a diploma for this, but we leave it to the people concerned to judge whether it would be valuable for them to hold our diploma, and at the moment a very great number of them do take it.—*Mr. Peel*: Just listening to Sir David and Professor Claye speaking, I wondered whether they appreciated the point that the year in a postgraduate pre-registration appointment, which is made compulsory by the General Medical Council, is something every graduate is going to go through. We believe as a College that only a certain percentage of general practitioners should practise obstetrics, and we feel that it is the men who have had special postgraduate experience who should fall into that group. Therefore we should not be in favour, I do not think, of extending the 12 months to 18 months, because we do not feel that it would be necessary for every doctor to have six months' postgraduate education in obstetrics.—*Professor Claye*: That is the position, Sir.

4316. But the young man at this stage does not quite know into what sort of practice he is going.——*Mr. Peel*: Yes, that is quite true, but he is not confined to taking an obstetric appointment, necessarily, in his first 12 months.

4317. In paragraph (vi), you say "The College has no evidence to suggest that there is in relation to the other branches of medicine an excessive number of specialists in training today in obstetrics and gynæcology". Are you satisfied that there are enough? You only give the limit on one side. Are you satisfied that there are enough in training?——*Professor Claye*: Yes, there are enough, Sir.

4318. You think that it is all right on both sides?——Yes.

4319. Then, you deal with the subject of tax relief. We have had a good many representations on this matter, and I think we have got the point here fairly clearly from all the consultant groups. Is there anything further that you would like to add, or have you any particulars,

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statistics or anything of that kind to supplement this?——No, I think I cannot put it any better than we put it there, Sir.

4320. *Mr. Gunlake*: There is a point in paragraph (vii) in which I was interested. You say "It is in the interest of both patients and consultants that there should be an opportunity for private practice. Whilst it is admitted that facilities exist, the cost to the patient is often prohibitive . . ." Can you enlarge on that a little, and indicate why it is prohibitive, and to what extent it is prohibitive?——I would like Mr. Peel to answer this, because I am not in private practice, and my colleagues are. —*Mr. Peel*: I think what the College meant was that the cost of private accommodation in hospitals is extremely high, because it is considerably over and above the overall cost of a bed; the patient is, in point of fact, entitled to a National Health Service bed from his own contribution. By taking the facilities in private accommodation, as he can, he is, in point of fact, not only doing what he wants to do, but is helping the Exchequer by providing additional funds towards the running costs of the hospital. It is merely felt by patients, consultants and general practitioners, that if the cost were reduced, and allowance made for the fact that the patient is relieving the requirement of a National Health Service bed, in point of fact, there would be an increase in the take-up of private accommodation. It would, in point of fact, ultimately be to the benefit both of the public and of the consultants, and, incidentally, to the benefit of the Exchequer.

4321. *Chairman*: How much is there in this in terms of money per week, if you like, for a bed? You are saying that the hospitals are charging too much?——That is so. Obviously, costs have got to be met. You would like us to quote the actual figures. The figures for private accommodation vary between, I would say, a minimum of 20 guineas a week and something like 35 guineas in some of the private beds at teaching hospitals.

4322. *Sir Hugh Watson*: In London? ——In London.

4323. *Chairman*: But how much of that do you think is beyond what is the real cost appropriate to that bed? You are saying that this cost is rather loaded so as to discourage the use of private accommodation?——Supposing the cost per bed in a hospital were £25 a week, then the cost of a private bed—I am only quoting roughly—would be about £30. So that the person contributing towards the National Health Service bed does not take up what he is entitled to, and he has to pay 25 per cent. more than the actual cost of the bed.

4324. *Mr. Gunlake*: Whilst you feel that the cost of the private bed is pitched too high, are you contemplating that it should be set below the economic level? As you know, of course, it is contended in some quarters that drugs should be supplied to private patients from the finances of the National Health Service. Have you anything similar in your minds as regards hospital beds for obstetric purposes?——We know there are arguments on the other side, but I think many people do feel that the cost should be set below the actual cost, because the individual is not taking up his entitlement. I do not know if Mr. Malkin would like to add to that, speaking from outside London.—*Mr. Malkin*: I do not know that I can say much more than Mr. Peel has already said. There is one point which has not been brought out, though no doubt it has on other occasions, that there are two positions. If a patient comes in as an ordinary National Health Service patient, and wishes to have private accommodation, in a lot of hospitals it is possible, by paying another 2 guineas a week, to have private accommodation; but if that same patient wished, at the same time, to pay a surgeon they would have to pay a large amount, as Mr. Peel has said—25 per cent. in excess of the actual cost —and in a way that seems a little hard. I think the figures Mr. Peel has quoted would apply to the provinces, where I come from. They would have to pay 20 guineas a week, but if they did not insist on a particular surgeon doing the job they would get it for 2 guineas a week.

4325. *Chairman*: Most hospitals have their own consultant gynaecologist and obstetrician, who would normally do whatever needed to be done?——Yes, but when the patients go in they are normally asked to say that they appreciate that no particular surgeon will do the work, and only overall control or responsibility is put on to a particular

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surgeon. But if they say "I would like Mr. So-and-So to do it", and they want a guarantee of that . . .

4326. Then they have to pay for exercising that preference?——Yes, and we feel that the difference between the two is excessive.

4327. *Sir Hugh Watson*: In the case you are talking about, they would be bringing in a surgeon who is not normally employed as a consultant in the hospital?——I did not mean that at all. Any private bed can be filled by any consultant, but that is unusual, at least, in the provinces.

4328. There is one expression which Mr. Peel used, which I did not understand, when he said that the patient is not taking up her entitlement. What did you mean by that?——*Mr. Peel*: Merely that, in paying her contribution to the National Health Service, the patient, if for example she is going to have a baby in hospital, is not taking an ordinary bed in the hospital; she frees that bed for somebody else. Apropos of that, there is one further point I would just like to mention. We had in mind that there was in obstetrics, rather more than in other branches of medicine, a particular desire on the part of the public for increased private accommodation in hospital, because of the very nature of obstetrics. So many patients do like the personal service of the doctor or obstetrician of their choice, and if private facilities were within reasonable bounds I am quite sure that the patients would take it up very much more than they do. There was the success of various contributory private schemes which were in existence before the National Health Service, which were very popular indeed with the public, but they have all been swept away by the National Health Service; and I think the public is missing something, or that section of the public which would take advantage of that facility is missing something.

4329. *Sir David Hughes Parry*: You partly answered the question which I had in mind to ask. It is based partly on a passage in your answer to question (vii). You say that if there was a diminution in the charges of the hospitals, this would result in an increased income to the Exchequer and the consultant.——Yes.

4330. In other words, it would be very largely to the advantage of the consultant that there should be more private practice. That is the point that you are making?——Yes, that is so, and we emphasise that, too, apropos of another aspect of the thing. There are a certain number of hospitals in different parts of the country where there may be rather inadequate cover by consultants for the general running and responsibility of the obstetric unit. In other words, it is far better to have two men available at consultant level looking after one hospital than have one who is full-time, because he cannot be on duty the whole 24 hours a day throughout the year.

4331. Many of the other bodies which have been before us have emphasised the importance of the continuation of private practice in the profession. I have not yet a clear view in my own mind of the advantages of being a private patient. I wonder if you could summarise those very briefly for us. You emphasise the importance of private practice for the consultant. Is it purely economic?——I would not say that for a moment, no. I think the economic factor is one factor, and it is an important factor. There are many other factors, though, and I would think that it is difficult to put them in a nutshell, but, if I can summarise it in this way, when one practises as a consultant in a hospital, one practises as the head of a team and the different members of the team have duties in relation to the conduct of the individual care of the patients. It is teamwork. In private practice it is quite different. It is an individual service given to an individual person, at his own request. As an individual who practises both ways, I think there is a great deal of satisfaction to be had out of both ways of practising medicine, surgery and obstetrics. I think that the profession and the public lose if a man is practising his profession, in either of those two channels exclusively. That would be the way I would summarise the thing. There are many aspects of this problem.

4332. *Mr. Gunlake*: The preservation of a sector of private practice is something that concerns other professions besides the medical profession. Would you agree that the preservation of an element of private practice is a very important means of retaining and preserving professional freedom?——I do indeed.

4333. There is a danger that that freedom might ultimately be lost, if private

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practice were ultimately to disappear? ——That is our belief, Sir.

4334. *Chairman*: In this particular field the doctor-patient relationship, which you are stressing, might very often apply to the general practitioner, who has dealt with the woman concerned right up to that moment, rather than the consultant whom she may not have seen very much. Are you implying that what you would like to see in the ordinary case is the general practitioner dealing with these cases in hospital?——I think there is room for both. I think we feel as a College that so far as private practice is concerned, as well as so far as the hospital service is concerned, there is a place for the consultant and there is a place for the general practitioner practising obstetrics, both in and out of hospital.—*Mr. Lewis*: As far as that is concerned, the abnormal obstetric patients choose to go to a consultant throughout the length of their pregnancy, and there you are likely to have the present doctor-patient relationship just as much with the consultant of their choosing, as with a general practitioner.

4335. I can quite see that in the abnormal cases, but the great majority of cases are not abnormal. You draw attention to the large number that are now going to hospitals, most of whom have, presumably, only been in contact with their general practitioner up to the moment.——Yes.

4336. So that if they go into hospital then, and they come under a consultant for the first time, from the purely psychological angle it does not make much difference whether it is a consultant allocated to them or one of their own choice?——Yes, that is so, Sir. We do mention the general practitioner obstetrician units which would be covered by that point.

Chairman: We will come to that later.

4337. *Sir Hugh Watson*: Can you give us any idea what proportion of births require the services of a consultant? Mr. Lewis mentioned the abnormal births. I suppose there are cases where consultants are called in, but there must be many thousands where a consultant is never called in.——*Mr. Peel*: It is a very difficult figure to give.—*Professor Claye*: I can tell you roughly what the state of affairs is in my own hospital. About 50 per cent of the patients who book are normal and remain normal throughout, or have no very significant abnormality. Then there are about 25 per cent who are booked early in the pregnancy, because they are abnormal; the other 25 per cent develop an abnormality during pregnancy and are booked late, because they have developed that abnormality. I do not know if that helps you.

Sir Hugh Watson: That gives me an idea.

4338. *Chairman*: Is yours a general hospital, or is it a maternity hospital? ——It is a maternity hospital.

4339. Probably, the proportion of purely normal ones would be higher, both in domiciliary births and in the hospital in general hospitals, would it? ——Than in maternity hospitals?

4340. Yes.——Certainly, the lowest proportion of abnormal births, obviously, is in the domiciliary class, but I would have thought there was no great difference between the maternity units in general hospitals, and purely maternity hospitals.

4341. Allowing for the domiciliary ones, this rather suggests that something like two-thirds never have any abnormality, and something like one-third have an abnormality either early on or late, to a greater or lesser degree. Is that a right conclusion?——About half remain normal; one-quarter are early bookings, on account of abnormality . . .

4342. Yes, but since only about 60 per cent of all births are hospital ones, probably about two-thirds of all births are normal?——Yes. You are taking into account the domiciliaries.

4343. Yes.——*Mr. Peel*: May I just clarify one small point, and that is that the condition that you visualise of the normal obstetric patient being in contact with the general practitioner throughout the pregnancy, and then going into the hospital under the care of the consultant, does not frequently arise, because if a patient has elected to have a hospital birth privately, under a consultant, then the consultant looks after the patient throughout the pregnancy. If it is under the National Health Service, then they attend the ante-natal clinic of that particular consultant, and are not merely in contact with the general practitioner. The only case where there would be a change of person is if what is thought

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to be normal becomes abnormal at a later stage; then there is a change of person responsible.

4344. Of the half of those who come to your hospital, who are completely normal from start to finish, most of them would not, in fact, require the care, at any stage of a full consultant? The delivery, for instance, would not require the attendance of the consulting gynæcologist?——*Professor Claye*: That is so, Sir.

4345. *Mr. Gunlake*: Still on your paragraph (vii), you refer to the question of full-time consultants and part-time consultants. This is a point on which we have had a good deal of evidence from other bodies. In the memorandum which was supplied to us by the Ministry of Health, which you may perhaps have seen, we are told that in the middle of 1956 there were 73 whole-time consultants in your specialty, and 391 part-time consultants, who were doing an average of about 8 sessions a week each. Would you care to comment on that picture? Is that about right in your view—the proportion between whole-timers and part-timers, and the average number of sessions—or do you feel that some changes ought to be made?——We have, of course, commented in paragraph (vii) about the desirability of consultants having a smaller number of sessions.

4346. May I take up that point? The average is 8 sessions a week. Included in that there will be people doing very few, so there must, obviously, be a number of people doing the maximum number of sessions. I gather from what you say that you feel there is too great a tendency for people to do too many sessions.——Yes, that was our case, Sir.

4347. *Chairman*: I was not absolutely clear on that. First of all, when you say that "a hospital is better served by two or more consultants with fewer sessions than by perhaps only one consultant with a maximum number of sessions", are you envisaging in the consultancy sphere something rather like a partnership in general practice?——Nothing as close as that, Sir.

4348. Not as close as that but, for instance, you rightly say that it is humanly impossible for one consultant to be constantly on duty day and night. In general practice there has been deliberately fostered an encouragement to form partnerships so that the same man will not always be called out every night; there is a sharing of these kind of responsibilities. I was wondering whether you were envisaging anything of that nature in that sense.——No, we were envisaging merely that where one man was off, the other could do his work under a sort of gentlemen's agreement.

4349. That is rather the same sort of relationship. The second thing is that if the consultant has fewer sessions than the maximum because of this, what are you envisaging he does during the rest of his time—private practice?——That is the importance of the first paragraph, Sir. We hope that, if this alteration were made, a man would get more private practice and that would compensate him for his loss of sessions.

4350. But he will still be on duty for the same amount of time looking after his patients, if he has the same number, whether they are private or public will he not?——Yes, but there will be more of him, as it were. There will be two, for instance, instead of one, so that he will have a deputy when he goes off; whereas, at the moment there are quite a number of places where there is only one consultant, and if he goes off there is no consultant.

4351. *Sir David Hughes Parry*: I take it there are registrars, so there will be someone on duty for the normal type of case in a hospital, will there not?——Yes, but a registrar is not a consultant, Sir.

4352. But the registrar will deal with anything except a real emergency, will he not?——Yes, but surely the point about a consultant is that he has been appointed because he is capable of taking the maximum responsibility, and a man who is in a registrar post is not yet in that position. He has to refer difficulties to the person who is capable of taking responsibility, and that is the consultant.

4353. But if it is a straightforward case, he may not have to refer it to the consultant?——No. There are plenty of cases like that, of course.—*Mr. Malkin*: I think the worry is felt in a rather small town with a population of 50,000, which is too small to have more than one consultant, so if that consultant is away for holidays, illness, weekends, or something like that, he has got to get some

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cover from the nearest town, which might be some distance away. Our view is that that is unsatisfactory, because of the possible emergency case. You could not encourage another consultant to come; he could not get a living as there is not enough hospital work, and he would not get enough remuneration if the sessions were divided down to four or so each. If it would be possible for each to do private practice to recoup on that, then we feel the hospital service would be better covered.

4354. *Chairman*: Supposing there are two consultants, each doing hospital work in 50,000 population towns, ten miles apart, for nine sessions, and suppose they so work it that they cover one another by each doing, say, four or five sessions in each of the two hospitals. Does that help you at all?——We thought it would. In practice it does not seem to have done so, because it has been tried. It means that one man would have to do all his obstetrics in one town, and the other man would have to do all his gynaecology away, because the distance might be too great to give adequate cover. It seems it is far more satisfactory to have two people intimately connected with one hospital, provided they can make a living, than to have them separated by a good distance.

4355. But they are still going to get the same number of patients in your town of 50,000 people?——Yes, but if there were more people able to pay private fees, which we think there would be if the cost of private accommodation were less, then the remuneration would be more or less the same.

4356. *Mr. Gunlake*: Is there, in fact, any other way by which the number of sessions could be reduced, other than by a greater volume of private practice? It is about the only solution we have had.——*Professor Claye*: Yes, we have not been able to think of one.—*Mr. Lewis*: The accent has been on the time the consultant is off duty. The position arises very frequently that he is busy doing a difficult operation on a case, and one of his obstetric cases starts to bleed. Under those circumstances, it is very useful, as we have found in London, where on the staffs of our hospitals we have several consultants, to be able to call in a colleague to cope with an emergency, while you are coping with another.

4357. *Chairman*: I can see that part quite clearly. I have not quite seen how the problem of the 50,000 population hospital is going to be greatly relieved, because I do not see how it is going to be able to employ at a satisfactory total remuneration two people, if it can only employ one now, even if they decide to have half their remuneration each from the hospital, and make it up by charging fees for the other half of the same number of births.——*Professor Claye*: We visualise that if the charges for private beds were not so exorbitant there would be a much better demand.

4358. Not more children born?——No.

4359. *Sir David Hughes Parry*: We now come to paragraph (viii) on the difficulties encountered by members of the registrar grades. In the second sentence there you say "With the limited number of consultant posts all registrars cannot hope to achieve consultant status. . . . " What registrar have you particularly in mind there? Is that all grades of registrars? I am not quite certain.——What I think we are visualising there is promotion from senior registrar to consultant.

4360. You say "With the limited number of consultant posts all registrars cannot hope to achieve consultant status. . . . " If that is so, there will be some who obviously, for some reason or other, will not be consultants. What suggestion have you to make about them, as regards their remuneration?——You know you are asking a very difficult one there, Sir.

4361. It is one of the great problems that we have to face, and we are asking you to help us.——Some of them, of course, go abroad, some of them take up academic posts, and I think some manage to get into some other branch. It is very difficult for them to get into general practice at that stage, as you know. It is much easier to get into general practice with the absolute minimum of hospital experience.

4362. We will come back to that in a moment. How would you react to the suggestion, which has been made to us, that a certain number of these people might be continued in salaried posts in hospitals for good, or until such time as they were appointed consultants?——We are against a sub-consultant grade, Sir, in addition to what we already have.

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There is the Senior Hospital Medical Officer, whom we were led to suppose would be a temporary grade, but he is still persisting. We have already got one sub-consultant grade, and we do not want another.

4363. How many people are really involved in this? What sort of number is it?——I wonder if Mr. Lewis would answer that. He is the man who can speak about the figures for senior registrars.—*Mr. Lewis*: It is extremely difficult to say how many are involved, but one can go by the number of applicants there are for various consultant posts which come up at the present time, and for an attractive post you can say there are between 30 and 50 applicants for each single appointment.

4364. They will all be senior registrars?——They will all be senior registrars, Sir. Some of them will be not completely fully trained, and they are trying to get known early; others are well beyond the five years of senior registrar, which would be regarded as the sort of time a man should do before he is fully trained, and some of them will have had just about the right amount of training.

4365. They will be from, presumably, the second, third and fourth years?——Yes, the second, third and on up to the sixth, seventh or eighth, perhaps. My present registrar is aged 36, and he qualified when he was 23. He is fully qualified. He has got every diploma, and he is among the 50 or so who have been putting in for the jobs. He has been short-listed for three out of the last seven applications that he has made. That is the typical sort of set-up at the moment.

4366. How many vacancies a year are there?——From the Ministry figures we are told that in 1963 and on for the next 11 years, there will be roughly 20; at the moment it is a few less, say 15 a year, but it will go up to 20. It depends on the ages of the consultants who are actually consultants at the moment.

4367. *Chairman*: I was just looking again at the evidence that you submitted to the Willink Committee, which is attached to this memorandum. That seemed to me to show that there was not a very large difference between the number . . .——Between the number that we are training and the number that we want? That is absolutely true. The difficulty is this pool of 50 fully trained men, who are now ready to go into an appointment.

4368. And I think you say you expect normally to have about 20 vacancies in consultancy a year.——Yes.

4369. The mere fact that 50 people apply for one job, does not necessarily make it very bad. It depends how often a job comes up, but you say it comes up about 20 times a year?——Yes. If all those who were now ready to go into consultant posts, and had done five years and onwards, got consultant posts, the position would be solved.

Sir David Hughes Parry: Would it? On page 914 it says that there are 36 in training, for whom there are only going to be 20 posts.

4370. *Chairman*: You get a wastage, do you not?——That becomes less if you follow on. We suggest that there should be 25 in the first year, and for each subsequent year.

4371. I was not even sure about that. You are suggesting that each one will do five years?——Yes.

4372. But none of them will get a consultancy until they have done five years?——That is the average.

4373. Not the average, but each one?——Yes.

4374. *Sir David Hughes Parry*: I do not think there are any further questions on the senior registrar, so I am going to ask a question on the junior registrar.——*Mr. Malkin*: Could I just mention one point? You were asking how we were proposing to deal with these senior registrars. It does follow on that, if it were possible to have more consultants by having a continuation or extension of private practice, it would obviously be possible to absorb quite a number of the present senior registrars.

4375. *Chairman*: In this evidence to the Willink Committee, you said that the total number of consultants and S.H.M.O.s was 580, and that when you had 90 per cent. of births in hospital you then thought a total number of 600 consultants would be needed.——Yes, Sir, and I think that is based on maximum part-time. That is not based on sessions.——*Mr. Peel*: It is rather based on the situation as it is at present. If the situation changed, and there were more consultants doing less sessions, then

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there would be a larger number of consultants required.——*Mr. Lewis*: Are you concerned with the jump from 580 to 600?

4376. No. I was meaning that it is not really a very large jump. I know the 580 includes the S.H.M.O.s.——Yes, Sir, and that jump included the required increases in establishment, which the various Governors' Boards and Regional Boards said they required.

4377. The total number was 580 in 1955, and is now how much?——We have no further figures.—*Mr. Malkin*: Those are based on present conditions, of course.

4378. *Sir David Hughes Parry*: May we take the position of the registrars, without the word "senior" before them? How many do you propose that there should be? You suggest on page 916, I think, that there should be 240. Is that right?——*Mr. Lewis*: A total number of 240. They are appointed for two years, so it would be half that number appointed each year.

4379. And you envisage that 120 of them would become senior registrars. What would happen to the other 120? I am concerned with them.——We thought that in the gradual training of an obstetrician there would be a point in his career when he could either go on or turn back, and we thought that that point was between registrar and senior registrar. We thought it was fair to train a man for two years, and at the end of that time to tell him that he was unsuitable, and that he would have to go in for another branch of medicine.

4380. *Chairman*: We have, in fact, to visualise promotion for only one in five of your registrars?——Yes. There are 125 registrars appointed each year for two years, at the end of which time of those 125 only 25 each year will become senior registrars. So one in five of the registrars will become senior registrars, and the other four have to do something else. Perhaps they go into general practice and do obstetrics in general practice. They will be well qualified to do so.

4381. *Chairman*: Do you anticipate or find at present that there is much difficulty about four out of five, for instance, of your registrars getting back into general practice then?——Not at that stage, Sir, no.

Chairman: At that stage transfer is reasonably easy?

4382. *Sir David Hughes Parry*: It is probably easier in this specialty than in some others?——I would say that it was probably easiest for a man doing general medicine to go into general practice from the registrar level. But I do not think it is very difficult for a man doing obstetrics.

4383. I had an impression that a general practitioner was more ready to have a partner who had some qualifications here, with a view to relieving the older partner.——From his obstetrics?

4384. Yes.——Yes, I think that is true.

4385. *Chairman*: You would like the senior registrar, then, to have been quite carefully selected, to have been through a careful process of selection at the transition from registrar to senior registrar, and some selection when he became a consultant? You do not want a guarantee that the senior registrar will be a consultant? You want to retain the competitive element, but you want him to have a very good chance? Is that right?——That is so, Sir. I think that the selection is at the appointment to senior registrar. We have suggested the training of 25 senior registrars for 20 consultant posts. We do not consider that the 5 or so, who do not get consultant posts, will go into general practice. We think that, perhaps, they will go abroad or do obstetrics somewhere else.

4386. You would still expect, I suppose, that some of them would have to wait a bit longer?——Yes.

4387. There will always be some overlap. Do you envisage some measure of security for senior registrars in the way of being put on the establishment at approved rates of salary, where they are what you might call time-expired?——I think that is so, Sir, so long as we are not faced with having in our hospitals men who are of consultant status who are permanently paid at senior registrar level, which is what we are very much against.

4388. By consultant status you mean taking the full ultimate responsibility, do you?——I mean a man fully trained in

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a junior position. That is, we do not want permanent senior registrars in our hospitals as a permanent thing. I think if we were allowed to prolong a man's appointment for, say one or two years over the average time, the five years, that would help.

4389. *Sir David Hughes Parry*: But it would not absorb all: some would be turned away?——We try to fix this figure of 25 being trained each year to absorb all. If we felt that was too many we might have to say 22 or 23. That was our aim in arriving at this figure; we felt all ought to be absorbed in some way.

4390. You do make the suggestion on page 912, that they be given part-time employment in the hospital service as clinical assistants. That is a temporary measure?——These are the two-year registrars, I think.

4391. These are the two-year registrars.——They go into general practice. Four out of five go in, and because they have done these two years might perhaps be given some obstetric appointment in a general practitioner unit or even in a hospital.—*Mr. Peel*: We think that this certain percentage of these men who have done a period as a registrar would be very suitable people to be general practitioner obstetricians. If given appointments as clinical assistants in some of the hospitals, not necessarily the big regional hospitals but certainly in general practitioner hospitals and provincial hospitals, they might well contribute towards reducing the total number of registrars required and help to relieve the situation.

There is one other point I want to make in regard to the registrar, particularly apropos our being a Commonwealth College: there are a considerable number of registrar posts which are filled by men from overseas at the present time. In fact they are a very important contribution to maintaining the number of registrars because the registrar post in our subject in many hospitals throughout the country is becoming an unattractive one and it is very difficult to get men to apply for registrar posts.

4392. *Chairman*: Is there a difference in this respect between teaching and peripheral hospitals?——I think that is so, yes.

4393. Have you any suggestions about how to make those equally attractive?——I think the only way you can ever make it attractive is by making it no longer a dead end job. If becoming a registrar for two years means at the end of that time there is nothing for him to do in that particular field, it is no longer an attractive post; and if such a man could go into general practice with a good experience of obstetrics and feel that he can make a useful contribution, it would be an outlet for a considerable number of registrars.

4394. It was put to us that very often the experience that you got in a peripheral hospital in this country was perhaps better than in a teaching hospital, was of a more general nature; the registrar was more apt to take decisions himself?——Yes, I think there is more practical experience with less controlled training if I can put it that way.

4395. I was thinking in terms of becoming a general practitioner to a registrar who remained a registrar with a view to becoming one of your four out of five.——Yes, it is a very excellent training for him.

4396. At the same time it is difficult to get these registrar appointments filled in the non-teaching hospitals on the periphery?——That is so, yes.

4397. There is no difficulty in the big teaching hospitals?——That is so, yes.

Sir David Hughes Parry: Your paragraph (x); I think we know now the great importance which you attach to private consulting practice as an incentive and really for the good both of the National Health Service and of the consultant himself. I think we have that point. I do not know that we need pursue it any further. Then the comparative treatment for income tax purposes, that again I think we have fully gone into with other bodies.

4398. *Chairman*: This fee of seven guineas to which you refer in paragraph (xiii) Professor Claye, that can cover a rather wide range of attention, can it?——*Professor Claye*: Yes, Sir.

4399. The seven guineas can be earned for rather little or a great deal?——Yes, it is the normal fee for a patient who

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books a general practitioner and goes right through.

4400. But the work required to earn the fee varies in extent?——It may or may not very much. As you know, the Ministry lay down a certain minimum of attention which is very much below what is the optimum. A man may do very little for his fee or he may, if he is a conscientious man or if the patient turns out to have trouble of one kind or another, get a very great deal more.

4401. This may be affected by the nature of the case?——Yes, Sir.

4402. But it may also be affected by the inclinations of the doctor?——That is the point.

4403. To the extent that it is the latter, would you feel it rather encourages the doctor with an overloaded list to do less? ——Certainly it does not discourage him.

4404. Have you any suggestions about that particular point? Would you like to comment further on it?——I do not think I would, Sir. This is really a purely general practitioner point. I do not think it is up to us to comment on it.

4405. We are always looking for opportunities for seeing how to reward good doctoring in general practice rather than simply taking the capitation fee method. I wondered whether you had anything to suggest on that at all?—— I do not think I have anything to say.— *Mr. Peel*: The only thing one might say in general, Sir, would be that in general practice, going back to this same old question that only a limited number of general practitioners really want to do obstetrics and are experienced to do it; we feel the better paid they are for that service the more they will be able to reduce their other commitments and the better service they will give in obstetrics to their patients. That is the general belief and I think it would be true. If better rewarded for that particular service they could cut off some of their other commitments with regard to capitation fees and the public would get better service from the doctor for obstetrics.

4406. *Sir David Hughes Parry*: I see what you say on the question of merit awards and the method of allotting them. We are aware of the criticisms, but I think you make none yourself? ——*Professor Claye*: Yes. The Chairman, Sir, at the beginning I think said if we wished to modify our opinion at all we could do so and I think that we have been unnecessarily lukewarm in our remarks about the merit award system. I think we do all want it. I myself have been a member of the Merit Awards Committee for the last few years. I cannot myself imagine any fairer way of recognising merit than this award. It is done with tremendous care and I cannot visualise a better way of doing it.

4407. Yesterday the Surgeons emphasised the fact that it was really a method of securing differences in remuneration. I notice in the way you present it today you indicate that it is a method of recognising merit.——Surely it can do both, can it not, Sir?

4408. I do not know.——I would have thought so.

4409. One wonders you see. It really was decided as a method of preserving differences in remuneration that was earned before 1948, was it not?——Yes.

4410. That was the object of it, was it not?——Yes.

4411. One wonders whether the word "merit" or "distinction" is not a part of the trouble in the minds of those who are critical of the awards and the method of awarding. Any observations on that?——I am not quite sure what you are getting at, Sir.

4412. I am sorry. You see the person who gets a merit award gets a better form of remuneration, does he not? Is it a question of paying a bigger salary or remuneration, or is it really a question of giving a merit award as such?

Chairman: You see, there are many more consultants now than there were at the beginning of the service. Of all specialties taken together therefore the number of people who get a merit award are far more than envisaged by Professor Bradford Hill who made his investigation of consultants' earnings at the beginning. It may be that the percentage of one-third at any one time of all consultants being meritorious may not be just the right conception. On the other

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hand it may be right, that one-third of all consultants should at all times be getting rather more than the basic consultant amount as a means of increasing their payment. I think that is putting it another way.——*Mr. Malkin*: Would not that imply, Sir, if it were just a means of remuneration that it would be automatic, giving security, whereas at the moment it is not? It is obvious security must be taken into consideration. I take it we would not have somebody on the top grade. There must be the additional standing for them, to recognise the work they have done; so I would say it was rightly called a merit award.

4413. But Mr. Malkin it is given to one-third of all consultants now whatever the number of consultants may be. That is right?——Yes, but then the standard of merit necessary must vary in an increased number of consultants. —*Mr. Peel*: Then surely the fact there are three grades of merit awards makes it rather more sense, does it not? At first sight one-third does seem a high percentage, but the fact there are three different grades of merit award, the lowest of which is not very different—I think only about a 20 per cent. addition to salary—makes more sense of the system. Essentially surely it is a method of maintaining the differential amongst consultants so that outstanding work and merit may receive additional remuneration and additional remuneration not merely to go on with but to provide security for a particular position.

4414. *Sir Hugh Watson*: Would you say, Professor Claye, so far as you know that the principles by which the allocation of these awards is governed are well known to all the people who are eligible for them?——*Professor Claye*: It has been well publicised in the British Medical Journal.

4415. Yes, but we had Lord Moran before us who told us how he did it. In his own mind he was quite satisfied that he and his committee had done everything that was possible to make sure that the claim of every consultant who was eligible for a merit award was considered and every consultant knew that. I gather you are one of Lord Moran's colleagues. Would you agree that is the position?——Yes. I think there is very little excuse for any consultant not knowing that.

4416. *Chairman*: Professor Claye, in your memorandum to the Willink Committee, you said:

> "In accordance with the opinion of the Council of the College that the posts at present filled by S.H.M.O.s should in fact be filled by consultants, the two appointments have been considered together."

In fact, in the total there are about, in round figures, 7,000 consultants and 2,600 S.H.M.O.s at present—not gynaecologists—in the total range of specialists. Now if your recommendation to the Willink Committee applied throughout that would add 2,600 people to the total consultant establishment. Would you think that made 900 more people, one-third of that number, deserving of merit awards?——*Mr. Malkin*: That was only recommended in respect of our specialty.

4417. You are only dealing with your own specialty?——*Professor Claye*: On the face of it I think the answer to your question is no, Sir.

4418. It would need some modification to take account of it?——Yes.

4419. *Sir David Hughes Parry*: That is all I have to ask, Sir, I think. Is there anything further you would like to add? Would you like to raise any matter I have not raised?——*Mr. Peel*: There is just one that occurs to me, going back to the very first page of our memorandum and I think your very first question, dealing with the amount of emergency work. I think one might express it in this way, that in some specialties the rate of emergency work is very low, but in obstetrics the birth of babies either normal or abnormal is evenly distributed round the 24 hours of the clock. Therefore inevitably there must be a great deal more night work and emergency work in obstetrics than practically anything else except perhaps emergency surgery. That was the point we wanted to emphasise I think so far as the remuneration side was concerned. We did feel there should be some method of recognising emergency work for those who practise in obstetrics.

4420. Does that mean a difference in remuneration for consultants?——No, merely a recognition of the kind of emergency work done by that particular individual.—*Professor Claye*: If I may say so, Sir, when the consultant makes

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out the work he does for his contract he is supposed to include a figure for his emergency work. This paragraph I believe applies solely to general practitioners. The consultant in making out his figures should allow for an amount of emergency work he is likely to get.

4421. *Sir Hugh Watson*: Making out what figures?——When we originally got our contract we were required to estimate the times we put in on the various parts of our work.—*Mr Peel*: I think we were meaning it as a continuation of that principle, that some recognition should be made.

4422. *Chairman*: There is just one point I would like to take arising out of that, Professor Claye. It is on the question of what you might call constructive work because I would suppose that in this field there is much scope for the general practitioner or the consultant to do a good deal of educational work in clinics—in the "Well Baby Clinics"—not a very euphonious term. If it is done by a whole-time consultant that is in part of his contract, but if done by the general practitioner presumably at the expense of some patients on his books. Have you any views as to the extent of this?——*Professor Claye*: I do not think we are well informed about the position of general practitioners with regard to that, Sir.

4423. Do you think there is scope? ——There is certainly scope.

4424. Do you think it should be encouraged?——Yes.

4425. Is that one of the things that among general practitioners really should in some way be recognised as good doctoring, to get a reward?——The word "merit" is getting a connotation—good doctoring, yes.

4426. Because we are anxious to find ways of helping good doctoring that is not solely related to the number of heads.——I certainly think that sort of work should be encouraged.

4427. *Sir Hugh Watson*: It was suggested to us the ideal doctor would be the one with a full list and an empty surgery.——Yes, Sir.

4428. *Chairman*: I do not think we have any more questions. You have made some comments in your last paragraph that are rather parallel to some that others have made and have a bearing on the Coleraine Committee, and it is for that reason we have discussed it with others. I do not think we need to question you further on that.——*Mr. Lewis*: This question of our increasing the time required for our diploma of Membership of the College: it was suggested by increasing it from three to five years we might increase the cost of training a man. In fact, that would not be so because if at the moment he took it after three years, he would take it during his second year as senior registrar. By increasing it by two years, he would take it in his fourth year as senior registrar. He would not be eligible to be a consultant until the fifth year. So merely giving him a diploma at a later stage would not alter the duration of his training or the cost of it. It would be merely giving his diploma at a later stage.

4429. *Sir David Hughes Parry*: Part of the training, indeed most of the training, is practical, but there are some lectures and courses, are there?——Yes, Sir.

4430. And study and reading?——And at one stage of his career he has to take his diploma.

4431. But the study, presumably he pays fees for the lectures, does he?—— If he attends a course; he does not have to attend a course.—*Mr. Malkin*: Usually just one course.

4432. It is lengthening the period of practical training?——Yes. The diploma would be the same. It would be the length of practical training.

4433. I should have thought also there was a parallel course which also would be lengthened?——No. He is working all the time.—*Professor Claye*: Mr. Lewis mentioned five years. As we are being reported I would like to make it quite clear there is no question of our increasing the time of training to five years at present.

4434. *Chairman*: We were talking rather in terms of your evidence to the Willink Committee three years ago. That

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was really what gave rise to this. Was that evidence public, do you know? I imagine it was.——I think it was, Sir.

4435. You keep on talking about "his" and "him". Just as a matter of interest—I do not think you told us anywhere—is this branch of the profession one which has a particular attraction for women more than men?——It is.

4436. What proportion of the Fellows of your College are women?——I ought to be able to answer that but I cannot. I am afraid I do not know. If you would like the figures we can certainly get them without any difficulty.

4437. I asked rather as a matter of interest than anything else. I think if you have no other points to raise that concludes the session. Thank you very much. It has been a very interesting and a very useful session.—Thank you, Sir.

(The witnesses withdrew)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

18

Eighteenth Day, Thursday, 8th May, 1958

WITNESSES

Society of Medical Officers of Health

Society of Medical Officers of Health (Scottish Branch)

Association of County Medical Officers of Health of England and Wales

LONDON
HER MAJESTY'S STATIONERY OFFICE
1958
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Witnesses

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E. HUGHES, M.D., Ch.B., D.P.H., D.P.A. ... ...
J. B. TILLEY, M.D., B.S., B.Hy., D.P.H. ... ...
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Scottish Branch
I. C. MONRO, M.D., M.B., Ch.B., D.P.H. ... ...

ASSOCIATION OF COUNTY MEDICAL OFFICERS OF ENGLAND AND WALES

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

EIGHTEENTH DAY

Thursday, 8th May, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. A. D. BONHAM-CARTER, T.D.
MR. J. H. GUNLAKE, C.B.E., F.I.A., F.S.S.
SIR DAVID HUGHES PARRY, Q.C.
SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C. (*Secretary*)
MR. J. B. HUME (*Assistant Secretary*)

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

(i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.

(ii) The quantity and quality of newly qualified doctors.

(iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.

(iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).

(v) The position and prospects of a newly qualified doctor.

(vi) Any trend to excessive resort to certain branches of the profession at the cost of others.

(vii) The relative advantages and disadvantages, financial and otherwise, of service as:—

(*a*) a principal in single-handed general practice,

(*b*) a partner in general practice,

(*c*) a whole-time consultant in the National Health Service,

(*d*) a part-time consultant with the maximum number of sessions,

(*e*) a part-time consultant with only a few sessions,

(*f*) a Senior Hospital Medical Officer,

(*g*) a doctor in any other sort of practice or employment.

(viii) The difficulties encountered by member of the registrar grades.

(ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.

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(x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.

(xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.

(xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.

(xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.

(xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.

(xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.

(xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.

(xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.

(xviii) Specific proposals for medical remuneration.

(xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.

(xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.

(xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

THE SOCIETY OF MEDICAL OFFICERS OF HEALTH

Memorandum of evidence submitted by the Society of Medical Officers of Health to the Royal Commission on Doctors' and Dentists' Remuneration.

1. This evidence is submitted as the result of a direct request contained in a letter dated 11th June, 1957, from the Secretary of the Royal Commission on Doctors' and Dentists' Remuneration ; a request which the Society feels it is its bounden duty to comply with, although it must be clearly understood that it is a scientific body and not itself directly concerned with terms and conditions of service of its members. The Society is, of course, very conscious of the fact that a stage may be reached in any group of persons when the absence of financial incentive may seriously affect recruitment to and the efficiency of the particular service.

2. The Society of Medical Officers of Health was founded in 1856. The membership was originally restricted to medical officers of health, but the constitution was widened over the years so that it now includes public health medical and dental officers in the employ of local authorities, in the Ministries of Health, Education, Housing and Local Government, Labour and National Service, Pensions and National Insurance, in hospitals, universities, laboratories, the Armed Forces, and Her Majesty's Overseas Civil Service.

3. The membership of the Society is now over 2,300 of which two fifths are deputy medical officers of health, senior medical officers and medical officers employed in departments, just under one quarter medical officers of health, one tenth retired, about one sixteenth medical officers belonging to the hospital service, including chest physicians, and roughly the same proportion of dental officers ; the balance comprising civil service medical officers (including those in the public health laboratory service), members of the Forces and those serving overseas, those engaged in academic duties, and others.

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4. The latest available figure for public health medical officers in the United Kingdom, exclusive of Northern Ireland, is 2,490.

5. The Society, therefore, being the largest representative body of public health medical and dental officers in the United Kingdom, is well able to speak for the profession on matters connected with the work of those branches of medicine and dentistry.

6. Since the British Dental Association is a negotiating body and giving evidence in connexion with dental officers, it has been thought advisable to reserve comments chiefly to medical officers rather than to impinge on the dental side.

7. There is a general agreement with the observation contained in the letter from the Commission of 11th June inviting the Society's views that the majority of the topics included in the list accompanying the letter in question are outside the specialised field of interests of public health medical officers. For this reason, it is proposed to offer comments on a proportion only of the topics referred to in the preceding sentence.

8. (v) "*The position and prospects of a newly qualified doctor.*"

Though a career in the public health service has its very real satisfactions, these differ in a nature from those of the doctor engaged in curative medicine. In place of the traditional personal doctor-patient relationship, he is, for much of his time, concerned with the community, rather than with the individual. Since his undergraduate training has laid its greatest stress on individual relationships in curative work, the young doctor who enters public health must have a special interest amounting to a definite sense of vocation.

9. The medical officer of health is the only doctor who is by *statute* required to hold a higher degree or diploma. It follows that every doctor who intends to make a career in public health will have to obtain a diploma in public health or its equivalent as early in his career as possible, in addition to any other non-statutory higher qualifications which may be of value to him. But while the doctor in clinical practice who is seeking non-statutory higher qualifications can proceed to them while he is actually working in a whole-time appointment at an appropriate salary, the doctor in the public health service, seeking the statutory D.P.H., has rarely such opportunity. He is commonly required to undertake a whole-time course lasting for a full academic year and it is most exceptional for an employing authority to pay even a token salary to an officer while he is taking such a course. In a limited number of centres it is possible for a doctor to take a part-time course for the D.P.H. and to do part-time salaried work, but in such cases the period of the course will be proportionately extended beyond one academic year, while the remuneration for the part-time work is unlikely to exceed about £600 per annum and will not be adequate to maintain a doctor who, being several years qualified, is likely to be married and to have a family.

10. The rates of remuneration for members of the public health medical service, are, in many cases, so inferior that some posts are advertised again and again over long periods without attracting suitable applicants.

The following table compares the rates of salaries in 1950 and 1957 for public health medical officers.

	*Rates of salary**	
	Industrial Court Award, 1950	*M.D.C. No. 27† 1956*
Medical officers employed in departments	£850 to £1,150 by £50	£1,050 by £50 to £1,200 by £55 to £1,475.
Senior medical officers	£1,250 to £1,650 by £50	£1,520 by £50 to £1,570 by £55 to £1,955.

* The Industrial Court (2285) Public Health Service, 8th December, 1950.
† Whitley Council for the Health Services (Great Britain). Medical Council: Committee C. 4th June, 1956.

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Medical officers of health. Local authority population not exceeding	*Minimum of salary scale Between*	
75,000	£1,450—£1,650 4 increments of £50	£1,740—£1,955 4 by £55 increments
100,000	£1,550—£1,850 5 increments of £50	£1,850—£2,175 4 by £55 & 1 by £50 increments
150,000	£1,750—£2,050 5 increments of £50	£2,070—£2,395 4 by £55 & 1 by £50 increments
250,000	£1,950—£2,250 2 increments of £100 1 increment of £50	£2,290—£2,605 2 by £105 & 1 by £55 increments
400,000	£2,200—£2,500 2 increments of £100 1 increment of £50	£2,500—£2,865 2 by £105 & 1 by £55 increments
600,000	£2,300—£2,700 3 increments of £100	£2,655—£3,075 3 by £105 increments
Over 600,000	At discretion	At discretion

In comparing salaries of doctors in the public health service with other doctors, it is important to consider not only the average maximum salary, but also the chances a doctor entering the service has of reaching a salary of, say, £2,000 per annum.

In evidence given to the Industrial Court in 1950, it was shown that about 90 per cent of public health service doctors received incomes of less than £2,000; on the other hand, approximate percentages were in the order of 42 for general practitioners, 45 for senior hospital medical staff and 55 for industrial medical officers.

Minor cost of living adjustments since that date will have reduced the figure of 90 per cent nearer to 85 per cent but they have not substantially affected this ratio. On the other hand, there have been general increases in other branches of the profession; but the relationship shown by the 1950 figures remains essentially the same.

11. (vi) *"Trend to excessive resort to certain branches of the profession at cost of others".*

The financial and other attractions of the clinical side of the medical (and dental) profession result in the large proportion of young doctors and dentists opting for the hospital service or private practice. A consultant post in which the holder may qualify for a merit award, with, perhaps, 9/11th contract with a Regional Hospital Board or Board of Governors, is manifestly a great attraction to a young man.

12. The fact that substantial allowances in relation to income-tax for expenses of part-time consultants and general practitioners are obtainable under Schedule D, makes their financial conditions much more attractive than those of public health medical officers under Schedule E.

13. The very real difficulty experienced at the present time in recruiting anything like enough, in quality as well as in quantity, of public health medical officers under the existing unfavourable conditions of salary, promotion, etc., is exercising a profound effect in the preventive field at a critical time. The results of hard campaigns against tuberculosis and the acute infectious fevers are bearing fruit, and much is waiting to be done to improve domiciliary service to the handicapped and the old and in the prevention and cure of mental breakdown responsible for filling nearly half the number of hospital beds available for all purposes under the National Health Service.

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14. (xii) *"Comparative treatment for Income-Tax purposes, etc."*

The Society does not propose to offer any comments on this topic at this juncture. Nevertheless, it is particularly interested in securing an increase in the number of appointments of public health medical officers as consultants in preventive medicine to hospitals, which although not affecting many officers in the field of social and preventive medicine at the present, is, the Society hopes, likely to do so in the near future. Reference has been made earlier to the discrimination affecting public health medical officers on the subject of income-tax allowances, expenses of membership of learned societies, and so on.

15. (xv) *"General comments on the system of merit awards and the method of allotting them with any suggestions for an alternative system."*

The Society does not wish to comment on the system except to say that whatever system is used for the recognition of merit or distinction should be applicable to all branches of medicine including preventive medicine. At present there are no medical officers of health receiving salaries equal to those of consultants with the top award.

16. (xvi) *"Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets* of practitioners."*

The present scales of salaries for assistant public health medical and dental officers and for many medical officers who have dependents to care for result in these officers having to accept a lower standard of living for their families and themselves than it is right to expect of professional people who have spent at least eight years in qualifying and obtaining a diploma in public health and, possibly, in acquiring other higher medical qualifications and a diploma in child health, industrial health, bacteriology, etc.

17. (xx) *"Proposals for specific machinery or procedure to be established for dealing with future discussions of medical remuneration."*

The salaries of public health medical and dental officers should not be related in any way to those of non-medical officers employed by local authorities.

18. The Society claims that its members, as members also of the medical profession, should have the same right of direct negotiation and appeal to arbitration without restrictions, which should be enjoyed by all members of the medical profession.

19. As was stated in the opening paragraphs of this submission, the Society is a purely scientific body, and, therefore, not designed for direct negotiation on financial matters.

20. The Society desires to emphasise very strongly that the findings of the industrial courts have been arrived at entirely in relation to salaries paid to the lay officers of local authorities. It is a matter of deep concern to the Society that the claim of doctors in the public health service to be treated as members of the medical profession and to be paid on that basis has been, up to the present, completely ignored.

21. Members of the public health service are at a special disadvantage with regard to superannuation benefits. Non-medical local government officers commonly join at a much younger age than is possible for medical officers. The former make small superannuation contributions for their earlier years, yet their pensions may be greater than those of medical officers. The payment of additional contributions for added years, which nearly all public health medical officers have to consider in order to increase the amount of their pensions, is a particular hardship.

A case may be cited of a medical officer of health who must contribute £250 a year in order to obtain the advantage of five added years.

* See appendix.

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22. Lastly, the Society feels very strongly that medical officers of health should be regarded as consultants in social and preventive medicine (as recommended by the Guillebaud Committee* and supported by the Central Consultants and Specialists Committee and Council of the British Medical Association); and it is only just that their remuneration should be related to that of consultants in curative medicine. Medical officers in the public health service, whether medical officers of health or engaged in some special branch of preventive medicine (e.g., in maternity and child welfare or as school medical officers) should receive increased remuneration commensurate with higher responsibilities or distinction.

The salaries of medical officers of health should not be less than the minimum salaries of consultants and the ceiling should not be less than the maximum salaries of consultants inclusive of merit awards.

C. METCALFE BROWN,
Chairman of Council.

H. D. CHALKE,
Chairman of Executive Committee.

SELWYN SELWYN-CLARKE,
Secretary.

The Society of Medical Officers of Health.
Tavistock House South,
Tavistock Square,
London, W.C.1.
24*th October*, 1957.

* Reports of the Committee of Inquiry into the cost of the National Health Service (Cmd. 9663) paras. 714 and 715.

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THE SOCIETY OF MEDICAL OFFICERS OF HEALTH

Budget for 1.3.56 to 28.2.57—Medical Officer*. County Council and part-time M.O. borough

	£ s. d.	£ s. d.
Income:		
Gross salary		1,531 19 9
Family allowances (8s. for part of year & 18s. for part of year) ...		30 6 0
Testamentary gift		113 2 2
Legacy (part)		401 0 0
		£2,076 7 11†
Deductions:		
Superannuation	91 18 4	
N.H.I.	17 11 0	
Income Tax	237 10 0	
	£346 19 4	
Net salary, etc.		1,729 8 7
Expenditure:		
Housekeeping		396 7 6
Housing:		
House purchase policy	202 10 0	
Rates (including water rate)	70 8 2	
Schedule " A " Tax	26 9 1	
Insurance	68 11 5	
Education policies (2)	106 15 7	
Repairs and replacements	52 14 5	
Furniture and furnishings	94 2 8	
		£621 11 4
Car:		
Tax	12 10 0	
Insurance	21 0 0	
Repairs	42 12 5	
Car hire purchase	164 2 0	
Petrol and oil	71 0 0	
		£311 4 5
Fuel and light		78 2 8
Telephone		30 0 0
Holidays		45 11 6
Subscriptions to learned societies, etc.		14 14 0
Personal expenditure (new baby, etc.)		231 17 2
Total expenditure		£1,729 8 7

* Aged 34 years; qualified 1948; holds D.P.H. and D.C.H.; wife and three children born 1952, 1954 and 1956; entered public health service in 1954.

† Mileage allowance is not included because this is absorbed by use of car on duty.

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THE SOCIETY OF MEDICAL OFFICERS OF HEALTH

Budget 1956—Medical Officer*. London County Council

	£ s. d.	£ s. d.
Income:		
Gross salary		1,103 11 0
Deductions:		
Superannuation	65 0 0	
N.H.I.	17 11 0	
P.A.Y.E.	74 0 0	
	156 11 0	
Net salary		£947 0 0
N.B.—No other source of income, except family allowances†.		
Expenditure:		
Housekeeping		260 0 0
Housing:		
Mortgage payments	181 10 0	
Rates (including water rate)	42 10 0	
Schedule "A" Tax	18 5 0	
Insurance	5 5 0	
Repairs and replacements	12 10 0	
		260 0 0
Furniture and furnishings‡		168 0 0
(including refrigerator	68 0 0	
and television set)	72 0 0	
Car:		
Tax	12 10 0	
Insurance	15 0 0	
Repairs	14 0 0	
Automobile Association	2 2 0	
Driving licences	10 0	
Petrol and oil	80 0 0	
less (mileage allowance)	15 0 0	
		109 2 0
Fuel (electricity and coal)		27 0 0
Telephone		11 0 0
Holiday (Easter week-end)		20 0 0
Subscriptions to professional bodies and journals		11 8 0
Personal expenditure		80 10 0
		£947 0 0§

* Aged 31 years; qualified 1948; holds D.P.H.; wife and three children, born 1949, 1953 and 1956; entered public health service 1955 after 5 years as general practitioner.

† Not shown because all expended on children's clothing cost of which is not given on expenses side.

‡ Includes primary acquisitions and not replacements.

§ No expenditure shown on education, because daughter of school age attends county primary school. No allowance made in expenses for depreciation of car or furniture. Expenditure on clothing for doctor and wife included in personal expenses.

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THE SOCIETY OF MEDICAL OFFICERS OF HEALTH (SCOTTISH BRANCH)

Evidence to Royal Commission on Remuneration of Doctors

Introduction

1. The Scottish Branch of the Society of Medical Officers of Health is the body which normally expresses the views of public health medical officers in Scotland, and it has in membership 240 of the 271 medical officers employed in public health work in Scotland.

2. The Scottish Branch, while appreciating that the Royal Commission is primarily concerned with the remuneration of doctors engaged in hospital and general practice, realises that the Royal Commission cannot disregard the remuneration of public health medical officers, since

(*a*) the remuneration of any one group of doctors must inevitably be taken into account as a relevant factor when consideration is given to the appropriate level of remuneration of any other group of doctors, especially as public health doctors are, like their colleagues, part of the National Health Service, and as recruits to public health are drawn from the same pool as recruits to other sections of the profession; and

(*b*) the disparity (which has existed and widened during the last nine years) between the remuneration of doctors engaged in curative work and that of doctors engaged in health promotion and disease-prevention has already had an unfortunate effect on the community, in that, while recruits to medicine as a whole have been numerically adequate or possibly slightly more than adequate, there has been a qualitative and quantitative shortage of recruits to the public health service; in other words, while there are plenty of doctors available to treat disease, there is a growing lack of doctors with post-graduate training in methods of preventing disease—a lack which is clearly detrimental to the well-being of the community; so that it is manifest that (since prevention is more comfortable for the individual than is cure, and also cheaper for the community) any alteration of medical remuneration should be in the direction of removing or reducing the existing disparity.

3. The Branch therefore offers for the consideration of the Commission the following notes about the functions, qualifications and salaries of doctors who have specialised in the field of disease-prevention and health-promotion.

Functions and qualifications of public health medical officers

(*a*) *The Medical Officer of Health* (and, in large units, his Deputy).

4. It may be appropriate to begin with two quotations.

(1) The Sanitary Officers (Outside London) Regulations of 1935 stated that the Medical Officer of Health shall

> "Inform himself, as far as is practicable, respecting all matters affecting or likely to affect the public health in the district, and be prepared to advise the local authority on any such matter".

(2) The Scottish Health Services Council (in a memorandum entitled "What Local Authorities can do to Promote Health and Prevent Disease", H.M.S.O., 1951) said

> "It is too easily forgotten that diseases like cholera and typhus fever were eliminated and diseases like typhoid fever were made rare by the work of the public health services. Where the achievement of these services in improving environment and thereby reducing epidemic diseases is remembered, it is often forgotten that these environmental problems are no longer the main concern of the Medical Officer of Health. Certainly he must still advise about water supplies, scavenging,

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Salaries of Public Health Medical Officers

16. (*a*) The Departmental M.O. (corresponding initially with the Registrar and later with the Senior Hospital M.O.) is at present paid £1,050–£1,475.

The disparity between that salary maximum, for a doctor likely to end his career in that grade, and the present salary of a senior hospital medical officer is startling.

(*b*) The Senior Medical Officer (corresponding with the Consultant) receives £1,520–£1,955—i.e. less than even a Senior Hospital M.O.

(*c*) The Medical Officer of Health (who in small units corresponds with the consultant and in large units has analogies with the Consultant with a merit award) may be exemplified by quoting the maximum for three types of population unit. [Two maxima are given in each case, because Local Health Authorities have been given a range of discretion, although in most cases Local Health Authorities simply give the lowest amount within that range.]

Population	*Maximum Salary*
Under 75,000	£1,960 or £2,175
150,000–250,000	£2,555 or £2,870
400,000–600,000	£2,970 or £3,390

It may be noted that in Scotland (out of 271 public health M.Os. including 52 M.Os.H.) only two medical officers of health have population units of 400,000 or above.

17. At this juncture it may be useful to point out that the health services of Local Authorities are in grave danger of collapse through general failure of Local Authorities in recent years to offer salaries and promotion avenues comparable with those made available in the treatment services: the notorious shortage of recruits to health visiting (a profession in which the rank and file members have for about seven years been paid less than ward sisters, the hospital career grade, despite the additional obligatory qualifications of health visitors, and in which senior posts as superintendent or tutor are few in number and glaringly underpaid), the shortage of domiciliary midwives (nowadays paid less than ward sisters in maternity hospitals), the shortage of local authority dental officers and the shortage of sanitary inspectors all bear eloquent testimony to the unduly parsimonious attitude of local authorities by contrast with the relative generosity of the central authorities; and the qualitative shortage of public health medical officers, public health dental officers, health visitors, domiciliary midwives and sanitary inspectors is graver and more alarming than the mere quantitative shortages, although even the quantitative shortages (e.g. of health visitors and dental officers) are far greater than those to be found in most other professions.

A word on "Administration"

18. The low salaries of public health M.Os.—or at least of M.Os.H. and Deputy M.Os.H.—are sometimes attributed to the fact that, although they are recognised to be doctors who have specialised in a particular field, part of their work is "administrative". This is, of course, a curious argument which certainly does not apply outside the National Health Service: the Secretary and Deputy Secretary of a Ministry are not paid less than the professional experts employed in that Ministry (e.g. the Secretary of the Ministry of Health is not regarded as worth less than the Chief Medical Officer or Chief Architect, although the duties of the former are purely administrative); the University Professor is not paid less than his Senior Lecturer, although (while both undertake teaching and research duties without supervision) the essential difference is that the Professor has to devote part of his time to administering his department; the Manager of a firm is not normally paid less than the Chief Engineer; the Headmaster of a school is not deemed less valuable than the class teacher.

19. It seems to be only in the medical field that "administration" is stigmatised. It is perhaps worth while to consider the point in some detail. Administration is essentially the art of getting things done: the machinery of administration is provided by executive and clerical staff. The head of the organisation determines the

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objectives. There are two classes of doctor whose administrative functions are comparable—the medical officer of health, and the medical superintendent of the mental hospital.

20. To take the medical superintendent first: he is undertaking clinical curative medicine on a specialist and consultant plane. He is also undertaking administrative duties within his hospital becausc his medical training and experience is essential for their proper discharge. That is to say, his administrative duties stem from his medical skill. If this were not the case an administrative officer without medical training, but with training in administration would be the appropriate person to appoint. The pattern of duties of the medical superintendent has evolved over many years of experience. He is responsible for the general supervision of the work of the medical staff, but the latter are not his assistants, and have a wide freedom in the discharge of their duties.

21. The medical officer of health informs himself of matters affecting the health of the community he serves, reports to the local authority, advises them concerning necessary action and puts into operation the schemes evolved. He holds his position because he has the whole technical knowledge gained by working in subordinate public health posts and in addition because he has the ability to organise his department so that the technical knowledge of his colleagues may be properly applied to the tasks in hand. In his case, too, his administrative duties stem from his medical skill.

22. Yet the medical superintendent of the mental hospital is paid as a consultant, whereas the medical officer of health is a consultant, paid at rates substantially below those applicable to consultants in the National Health Service although he is carrying out medico-administrative work of a highly skilled nature, and his colleagues ranked as senior medical officers and also carrying out consultant duties, are less well paid than even senior hospital medical officers; and his junior colleagues are condemned to perpetual registrardom.

23. It has also to be remembered that many senior clinicians devote a considerable part of their time to administration.

Effect of existing disparities

24. In the nine years which have elapsed since the commencement of the National Health Service many medical officers of health have seen their erstwhile junior colleagues translated to the ranks of hospital consultants. The tuberculosis officers, venereal disease officers and infectious disease specialists, who were formerly on the staff of a medical officer of health, have benefited; so also have the mental hospital superintendents, obstetricians, and other consultants. Not a few medical officers of health are in the position of having received £10,000 less in salary since the start of the National Health Service than these erstwhile junior colleagues. Naturally, this golden glitter around the hospital gates has diverted inwards many young doctors who would otherwise have looked to public health as a proper career. Who can blame them? Nevertheless, the dogma "prevention is better than cure" remains as true as ever, even though the National Health Service tends to make cure more profitable than prevention. The preventive services must secure their quota of good recruits. It is essential to promote health and prevent illness through well-developed maternity and child welfare services, school health activities, measures for the health-maintenance of the elderly, and so forth. It is essential to attract to the preventive field doctors able to undertake research into and prosecute campaigns for improved mental health—over half our hospital beds cater for mental ill-health—for social health, for reduced delinquency and absenteeism. These are the fields of today and tomorrow for the medical officer of health. The national interest requires that he shall receive adequate financial rewards, comparable with those of his hospital colleagues.

25. The curative services at best simply restore the *status quo*. The task of the public health services is to improve the health of individuals and of the community. It is therefore economically essential for the well-being of the community that professional posts (medical, dental, health visiting, nursing, etc.) in the public health services should carry remuneration, promotion prospects and conditions of service at least as good as are available in the curative services.

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Examination of Witnesses

DR. H. D. CHALKE, *President*
DR. E. HUGHES
DR. J. B. TILLEY
DR. I. C. MONRO, *Scottish Branch representative*
SIR SELWYN SELWYN-CLARKE, *Medical Secretary*

on behalf of the Society of Medical Officers of Health and the Society of Medical Officers of Health (Scottish Branch), *called and examined.*

4438. *Chairman*: Dr. Chalke, you will be leading the discussion, as it were, with Dr. Monro representing Scotland? Has that got any special significance or are you really on this occasion pretty well as one?——*Dr. Monro*: I have a separate memorandum on which to speak Sir.

4439. *Chairman*: I must start, I think, by reminding you, Dr. Chalke, of the correspondence which took place just about a year ago between Sir Russell Brain and the Prime Minister, and our own public statement issued later. We know there was a strong feeling in the medical profession that their colleagues in the public health service should not be excluded from the scope of the Commission's remit and the Prime Minister was asked whether the terms of reference included them. The reply was that the remuneration of doctors employed by local authorities is excluded from the scope of the Royal Commission's recommendations, but any claim on their behalf through the usual machinery would necessarily be considered in the knowledge of any recommendations we may make. A public statement of the Commission followed, saying that the Commission are not asked to recommend remuneration for doctors and dentists employed by local authorities, but that these doctors and dentists are among the "other members of the medical and dental professions" on whose remuneration evidence will be received for the purpose of comparison. That is what we are doing today, and within that scope we hope you will feel free to talk as widely as you wish. We shall be asking you many questions, but it must be understood that recommending how much you should earn, is not within our terms of reference.——*Dr. Chalke*: We understand that, Sir, and we are very grateful for the opportunity of being able to say a few words. We are purely an academic body. Our evidence here and the verbal evidence we shall give is based on that fact. We are speaking as an academic body and not as a body concerned specifically with medico-political matters.

4440. Dr. Chalke, I should remind you that this is a public hearing, therefore whatever you want to say will be heard by the public who, I see, include some of your colleagues from the Association of County Medical Officers who we are going to hear a little later.

Naturally we will want to question you thoroughly on your memorandum because, if we do not, nobody else will. We probably will not need to take a very long time because a good many points have been canvassed very thoroughly with a number of other bodies, so we will be concentrating primarily on those particular to you. I hope, however, that you will not take it for granted that those points we do not challenge or take up are accepted, or equally that they are considered irrelevant. It will be just that we do not need to question you about it.

We have allotted, as you may know, the task of looking at the various memoranda of evidence we have received, to sub-committees under our two legal members and in this particular case Sir David Hughes Parry will be doing most of the questioning. But of course you may get questions by anybody, and equally if you prefer one of your colleagues to answer any point, that is perfectly in order.——*Dr. Chalke*: Thank you, Sir.

4441. *Sir David Hughes Parry*: Dr. Chalke, I just want to get your paragraph 1 quite clear. You do regard yourselves as a scientific body, not concerned with remuneration as such?——Yes, that is in the terms of our constitution. We are precluded from anything else.

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4442. Yes, but I take it that you are anxious to have a contented set of members and that you want to recruit the best persons possible into the profession; that is your real interest?——That is the basis of our thesis, as it were.

4443. We recognise that, I think. I will have the opportunity later of asking the County Medical Officers in what way their Society is different from yours, but I think that question I had better reserve for them. You mention in paragraph 2 the type of person who is a member of the Society. Are they all doctors, qualified doctors?——There are a number of dentists, and one or two non-medical hygiene officers in the Services. Perhaps I should say that 99.9 per cent are doctors.

4444. Are they all full-time or some full-time and some part-time?——There are a few part-time but there again the vast majority are full-time career people in public health.

4445. You have partly answered the question I was going to ask next. You seem to cover a fairly wide field. What is the binding force that brings them together into one Society?——Hygeia! Preventive medicine. We have expanded very considerably recently in many new fields of preventive medicine.

4446. *Chairman*: But preventive medicine is found in other branches of your profession, apart from the purely local government one?——Yes, Sir.

4447. *Sir David Hughes Parry*: And the British Medical Association also has a public health branch or division?——The Committee, of which Dr. Tilley is the Chairman.

4448. Your first main point, I think, comes out in paragraph 8—"The position and prospects of a newly-qualified doctor". Naturally we are greatly interested in that. You say in your last sentence:

> "Since his undergraduate training has laid its greatest stress on individual relationships in curative work, the young doctor who enters public health must have a special interest amounting to a definite sense of vocation."

I am not quite certain what you mean, whether you imply there is a neglect in the teaching of preventive medicine at the universities or what?——Sir, I think it is safe for me to say that not only recently but also in the last decade there has been too much emphasis on disease in hospitals and not enough on prevention; and the young student who has the idea of spending his medical life in the work of prevention has to learn a great deal that he should have learned in his academic training.

4449. *Chairman*: You say "in the last decade". Do you mean that has become more pronounced than it was?——I think, Sir, the emphasis has been, since 1948, on curative medicine and treatment, much to the disadvantage of prevention.

4450. But was that the position before 1948 or do you say there has been a swing?——There has definitely been a swing.

4451. *Sir David Hughes Parry*: I am driving at the question of recruitment. If I may use this expression, the noses of the young people are not turned, when at the university, in the direction of public health; is that fair?——*Dr. Hughes*: I think that is a very fair comment, Sir. In fact I believe, if I may say so, that the undergraduate instruction in public health in certain medical schools has been certainly played down in our time. I think it is almost true to say that it has been almost omitted in the M.B. examination.

4452. That may be an element affecting the question of recruitment as well as remuneration. It is against your own interests, but that may be so?——*Dr. Chalke*: I do not think so. I think, in medicine there are fortunately still a large number of people left who think their rôle in medical life is the preventive side; those people still exist, despite the lack of remuneration and lack of status compared with other branches of the profession.

4453. I do not know whether there is anything further you would like to add to paragraph 8?——Whether you would include recruitment in that paragraph, Sir—Dr. Tilley might like to say something about the whole question of recruitment.

4454. I think we had better do that on paragraph 9. The first point you make in paragraph 9 in effect is that the medical officer of health is the only doctor required by statute to hold a higher degree or diploma. Let us hear a little about the diploma. Is it a hard test?——Very hard, Sir, and in addition it is

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a diploma which cannot, in contradistinction to the Membership or the Fellowship of a Royal College be obtained when the young doctor is going on with his job.

4455. How many places are there where the diploma is granted—eight or ten?——In the region of eight or ten. Some of them in fact have had to close down within the last few years.

4456. And they have all got a limited number of students?——Yes.

4457. And a fair number of those students are in employment in the particular town where they are studying, is that right?——No, that is the point I am trying to make. To get the Diploma in Public Health, one or two local authorities now have schemes whereby they will allow people to enter the local authority service part-time and do a certain amount of work in the service, and take the part-time curriculum; but the majority of people have to do nothing else for a year whilst they are studying for the Diploma in Public Health; they are not earning anything.

4458. *Sir Hugh Watson*: Do they qualify for grants?——*Dr. Tilley*: No, Sir. I know of no occasion on which anyone taking a Diploma in Public Health course has qualified for any grant from a local authority or elsewhere.

4459. *Chairman*: At what age is this year when they normally take the D.P.H. course?——About the age of 28, I should imagine; 27 to 30 probably.

4460. *Sir David Hughes Parry*: At what stage do they take it? Is it after qualifying or do they take it after sampling general practice or after being registrars or what?——*Dr. Chalke*: It depends. It has changed a little recently but I imagine, after qualifying a doctor gets the urge to take up public health as a career and then he tries to find ways and means of getting his D.P.H. Some people do it after their national service; having seen the extraordinarily fine preventive service in the Army, they make up their minds to take up public health and then they have to find the money to cover the fact that they are not earning for a period while they are taking it. So, generally speaking, I should say it is two or three years after qualifying.

4461. *Mr. Bonham-Carter*: Dr. Chalke, is there any entry into the service at a considerably later stage in a doctor's career?——Yes, Sir. There is another point mentioned later in our memorandum in another context, the paucity of entrants and people who apply for jobs at the present time. Some people have come in much later. I think it is fair to say there were other forms of entry into public health in the old days. For example the chest physician, the tuberculosis officer who in the past, as you know, was an employee of the local health authority and very often a deputy medical officer, came in that way.

4462. *Sir David Hughes Parry*: But at all times he is faced with the situation where he has to keep himself probably for a full twelve months?——Yes, Sir.—*Dr. Tilley*: Certainly for an academic year.

4463. It would be interesting to us to know if you have any views as to the sort of time at which it would be ideal for them to enter. Should they have been in general practice to see that before they enter, or would it be better for them to take an appointment, if they can get it, as a registrar? Have you any views on the desirable time at which they might enter, as a general body.——*Dr. Chalke*: Sir, I would say, again in the past, the person who became a medical officer of health eventually had done a host of jobs, had spent time in a fever hospital, or a venereal disease department; he had been a tuberculosis officer and then very often he had been a house physician in a children's hospital. There are so many facets of public health work. The wider the experience of the individual parts of the service the better. Most of us have done a little time in general practice, six months or a year, or some locums. All of us have done jobs in hospitals, in some cases quite senior jobs, and it is after that we have come to this wider field. Preventive medicine is the only branch of medicine at the present time which has innumerable facets. There are no branches of medicine in which preventive medicine does not take an interest.

4464. I see also, Dr. Monro, that you raise this matter in your paragraph 14. I do not know if there is anything you would like to emphasise on that.——*Dr. Monro*: That is the point of the statutory obligation?

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4465. The statutory obligation and the time at which the persons enter into the field of public health.——I for my part took my Diploma in Public Health just on nine years after qualifying in medicine. I did it late because I had sought a career in one of the colonial medical services and after three and a half years, in all five years overseas, I found myself physically unfit; so you may say I decided upon public health approximately four years, or rather entered public health approximately four years after qualification. Last year I took on two new doctors to the staff. One had just four years from his date of qualification and the other rather longer, about six or seven.

4466. That would be typical or normal?——I think so, except where you are dealing with women, because a woman does not have her national service and there is, I think, a certain attraction to women to go into the maternity and welfare services; they may see that as a career and vocation rather earlier than a man going in for public health would see the whole field of public health as his vocation.

4467. It may be that when the Vice-Chancellors of the Universities are before us we might take the opportunity to ascertain the number of those who are being trained in public health at the different universities and those of them who are full-time in training and part-time. I have an impression there may be quite a fair number in part-time employment during their training but it may be we will get those figures from the Vice-Chancellors.——*Dr. Chalke*: There is one danger there, Sir; although no doubt the numbers of people taking the diploma are up or at least have not fallen very much, a very large proportion of them in London and other Universities are people in the Services. Nowadays in the Forces everybody is encouraged to take a Diploma in Public Health: so the numbers, though large, are very largely due to people who do not enter civilian public health.

4468. *Chairman*: When they are in the Services taking this, is that also without remuneration or can they take it while they are serving officers?——Yes, Sir. In the Services the D.P.H. has perhaps a higher status than in civilian life. As you know, senior officers are asked if they would like to take a higher qualification, and a lot decide to take the diploma of public health. In the Army it is called Army Health and it automatically carries specialist rank; so the Services at least recognise their status as specialists.

4469. He is seconded and is still being paid by the Forces and is able to go on earning while he gets his D.P.H.?—— Yes. I am not qualified to speak for the Services but I am quite sure that is what happens.

4470. *Mr. Bonham-Carter*: Do you know if the men going into the Services are National Servicemen? Is this a situation which is going to change materially if and when National Service comes to an end?——No, Sir, they are not National Servicemen but career people in the Services who want to become specialists; they decide on public health and stay in the Services. They know they can get equal rank, status and pay with a consultant or surgeon, physician and so on. There is equality in the Services.

4471. *Chairman*: Is the D.P.H. a useful diploma for people to have who are not in the public health services?——Yes, Sir. I would like every general practitioner and every consultant to have it.

4472. Do many general practitioners or consultants have it?——No, Sir.

4473. *Mr. Bonham-Carter*: Or industrial doctors?——Some do.

4474. *Chairman*: Do you know how many people on the medical register, for instance, have the D.P.H.?——I would not hazard a guess, Sir. You mean, altogether?

4475. Yes.——Two or three thousand, would it be? I have no idea.

4476. You have 2,300 members yourself?——Yes, Sir.—*Dr. Hughes*: First of all, Sir, on this question of length of period before you enter the public health service: at my time I had done seven years in various hospital jobs and I think that is fairly typical. Now of course the National Service commitments do alter things quite a bit. But it is a fairly long period before a young doctor decides on a career. On the question of industrial medicine in the D.P.H., it depends on which school you qualify in. At the School of Hygiene, for instance,

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it is possible to take overlapping courses, industrial health and public health, and a great many people do back the thing both ways.

4477. *Sir David Hughes Parry*: If I may summarise, as I see it now in the light of your replies, as compared with a person going into general practice, the person who goes into public health has three, four, five, six or seven years of some general work either in the public health field, or specialising in tuberculosis or something of that kind, and therefore his training is longer than the training required for the person to enter into general practice. As regards consultants on the other hand, we have evidence to the effect that it takes at least seven years to qualify to be considered for a consultant. Would it be right to say that your period of training is not quite so long and perhaps not quite so competitive as that particular period of training?——*Dr. Chalke*: With the proviso that in our period we are earning nothing when we are taking the D.P.H. and very little when we are doing the house jobs before it. But we must not forget a very large proportion of the people have higher qualifications in addition to their D.P.H. There are a number of people, members or fellows of the Royal Colleges, and certainly doctors of medicine in public health as a whole. In fact to get the senior posts in public health one requires to be well qualified.—*Dr. Monro*: One additional point, Sir: their training in public health does not end with securing the D.P.H. and securing their first appointment. It continues thereafter.

4478. The training of none of us ends with an appointment.——No, but the training does not end with entering the service.

4479. *Mr. Bonham-Carter*: I wonder if you would explain that, Dr. Monro, following Sir David's remark. Do you have to go on with a particular line or course of study?——Not in that sense, but the new entrant is set to work of a kind he has never done before and he has to gain experience and judgment. For instance, it is only after he gets his first appointment that he perhaps comes up against the difficulties of deciding if a child is mentally defective.

4480. *Chairman*: But that surely is as Sir David said, something that must happen in every profession?——As I understand it, Sir, that phase is gone through by the senior registrar. In other words our public health new entrant and the hospital senior registrar entrant are comparable. Both are doing useful work but both are still learning their jobs.

4481. *Sir David Hughes Parry*: I think I have that point. May we move on to paragraph 10? You use the word "departments" there. I am not quite certain—is this a department of central government or local government? I thought it was a department of local government.——*Dr. Tilley*: This is a term, Sir, first used by the Committee which sat under Lord Askwith. This is a term used for the basic doctor in the public health service, the school medical officer or the doctor working in the child welfare service, that is, a doctor working in the school health department or the child welfare department of a larger health department. That is the reason for the term, if you like, "departmental officer"—not a doctor in charge of a department, but a doctor working in a department.

4482. Who pays him? Is it the central or the local government?——Directly, Sir, the local government authority.

4483. *Chairman*: Is he, for administrative and disciplinary purposes, responsible for instance to the director of education or to the medical officer of health?——To the medical officer of health, Sir.

4484. In your case as an example, Dr. Tilley, taking a good sized county, how many doctors would you have responsible to you?——In this grade, Sir, about fourteen; fourteen whole-time doctors in this particular grade responsible to me.

4485. I suppose in a borough like Reading, being more concentrated, you would not have so many?——*Dr. Hughes*: I have five, Sir, plus a deputy.

4486. Five in this grade?——Yes, Sir.

4487. *Sir David Hughes Parry*: What proportion of these are in your 2,000 members? Does this particular grading cover the majority of your members?—*Dr. Chalke*: I think so.

4488. You have a fair number of persons who are not paid directly by the local authority. I am just wondering how many are covered by these figures.——You are referring to paragraph 3 as well, are you, Sir David, in which we give roughly the proportions?

4489. *Chairman*: Yes, you say 2,300 members but 40 per cent of them are employed by local authorities under medical

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officers of health, 25 per cent are medical officers of health and 10 per cent are retired. That is the paragraph you are meaning?——Yes.

4490. What proportion of the 40 per cent would really be in this grade—medical officers employed in departments with a salary range rising to a maximum of £1,475?——*Dr. Tilley*: Certainly more than 50 per cent.

4491. And most of them under, say, age 40 to 45 or up to all ages?——*Dr. Chalke*: Most of them under that age. It is difficult to say but the large majority are in that category.

4492. *Sir David Hughes Parry*: There is another question on the figures there. You give the figures under the 1950 award and then the 1956 award, and then you say "over 600,000—at discretion". I wonder how many there may be of those. I want to see the structure.——*Dr. Monro*: There is only one in Scotland.—*Dr. Tilley*: Speaking without checking this, Sir, I think about 12 to 14 in England and Wales.

4493. Between the 400,000 and the 600,000? This is only for the purpose of seeing the structure.——*Dr. Monro*: Again, only one in Scotland.—*Dr. Tilley*: More than 12, Sir. It is a pyramid, if you like, with the London County Council at the top of course—the one single office—the London County Council with a population of over 3 million. Then there are three authorities, I think, with 2 million population and then about four with 1 million, including Glasgow and Birmingham, and it spreads out; but the vast majority are well down below the 400,000 of course.—*Dr. Chalke*: A graph, Sir, or public health salaries is flat rising practically not at all, until the sharp peak at the end; so different from other grades in which they do go up gradually, and there is not that final sudden peak ta the end.

4494. Paragraph 13, which is a matter causing a certain amount of disquiet, naturally, the one where you declare that there is a difficulty experienced at the present time in recruiting anything like enough in quality as well as in quantity. Shall we deal with the quantity first? Do you know of any recent appointments, in your experience? I would like to know how many applicants you had, that sort of thing; that would give us some clue. ——*Dr. Hughes*: I think it is a thing that has worried us all. Up to about two years ago when I used to advertise for an assistant, one got hardly anyone at all worth considering. We did in fact introduce a special training scheme but we are rather unusual in that. That has improved, but the quantity was very small indeed, and certainly did not include many people who wanted to take public health as a career. And it was because of that that my Council agreed to have what we call an assisted training scheme. We are unusual in that but it was because we were so dissatisfied with the quality of the applicants and the quantity of applicants and also the length of time they stayed.

4495. Have things improved in the last two years?——Perhaps I should not take this example as typical because we have introduced a scheme to help people. We have said they have to have the D.P.H. or get it as soon as possible and we are prepared to second them on three-quarters the minimum salary. We have had better applicants since then and in return we ask them to stay for three years afterwards. I am hoping that is going to show an improvement in the situation but that type of scheme is very unusual. I think my colleagues will share the experience I had two or three years ago.

4496. Have you had more recent experience? Is it better now?——We have just made the second appointment under this assisted training scheme and I am hoping that will see us through for the next two or three years at any rate.

4497. And the applicants were better? ——They were men anxious to take up public health as a career, which was one of the things we were after.—*Dr. Chalke*: My experience—I remember the difference now from 15 or 20 years ago or even more, when one applied for appointments oneself. There was always an enormous number of applicants then. My experience in the last year or two has been there are very few men, a large number of women, but very few men applying for appointments who were quite obviously the type of person who before the war came into the public health on a career basis. There are very few of those people and there is a strong tendency for people not to stay in as long as they did before. In my youth, if you went into public health that was your career and you stayed there.

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Now there is a tendency to go out if you can. It has been very hard in the post-war years to get a suitable male who we are quite sure will stay and whose aim is to be a medical officer of health.

4498. So you are satisfied there is not the number? That is what I am concentrating on. There is not now, and there was before the National Health Service?——Yes, Sir.—*Dr. Tilley*: I think that is quite clear and every authority in the country would confirm that the number of applicants is very considerably less than it was before 1948. The thing that concerns us very much at the moment is that, of those who do apply, we do not see in them the quality that we would hope to see for the leaders of preventive medicine in this country in the future.

4499. It may be that that can be improved with these assisted schemes of training?——That may be so, Sir. But, Sir David, you did ask earlier if the training of a man going through the public health service was less competitive than the consultant. I think that perhaps at the present time if by competitive you mean competition to obtain posts and advancement, one would have to accept that that was so. But it was not so prior to 1948 and what has changed of course is the relativity of the remuneration that one may earn in the public health service as compared with the other parts of the State medical service. It is on that basis that I doubt very much whether even with assisted schemes of training for the Diploma in Public Health, we can expect as many of the most able men and women to come into public health as we could if the prospects in the two services were comparable.

4500. *Mr. Bonham-Carter*: Dr. Hughes, you made the point that one of your difficulties has been that men have left the service. You have not been able to keep them and Dr. Chalke, I think, confirmed that. Do you mean they leave your own particular authority or that they went out of the public health service altogether?——*Dr. Hughes*: The Press is here and I hope they will be discreet. I work for a pleasant town and a good authority. I hope they will not think I am criticising my authority; but in the last two odd years I have had four people leave, the first after six months to industrial medicine, the second stayed about twelve months and then went to a senior post in a large city. The third stayed six months and went to America to become a medical officer of health himself in Carolina or somewhere like that, and the fourth is leaving to go to America next month. I will stress again that I have a very good authority and it is a very pleasant town I live in.

4501. I can confirm that.——If I might ask for that to be treated with discretion.

4502. *Chairman*: All four remained in public health?——One has gone into industrial medicine, two have gone to America and one has remained in this country.—*Dr. Chalke*: A large number went into industrial medicine and other branches after the war, I am sure partly for financial reasons.

4503. *Sir David Hughes Parry*: Dr. Monro, I think you pay a good deal of attention to that in your paragraph 17:

> "At this juncture it may be useful to point out that the health services of Local Authorities are in grave danger of collapse through general failure of Local Authorities in recent years to offer salaries and promotion avenues comparable with those made available in the treatment services."

That is a matter which concerns us.——*Dr. Monro*: I think that is quite true, that we are just not getting the right kind of people and we are not getting the right numbers. Two years ago I had two vacancies and they were duly advertised. There were four applicants. One was already working in an industrial concern, a nationalised industry, and he found he could not afford to come back to a local authority public health service although he would have liked to do so. One was an Indian lady who had just completed her D.P.H. She wanted a restricted period of experience in this country, and I regretted being unable to help her out—I would have liked to but things being as they were I did not feel justified in doing so. The other two: one was a woman in her middle thirties with good general practice experience and she has done all right so far in public health, and the other was a married woman in her forties seeking to augment the family income. Neither of these two had the D.P.H. They both settled down adequately, doing the kind of work within their capacity, but they will never advance in public health.

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4504. Thank you very much. I think you have made your point, to which we must pay attention. Can we move forward to paragraph 14? Something has gone out of place here. It is headed "Comparative treatment for Income-Tax purposes, etc."

"The Society does not propose to offer any oomments on this topic at this juncture. Nevertheless, it is particularly interested in securing an increase in the number of appointments of public health medical officers as consultants in preventive medicine to hospitals . . ."

I am not quite certain how the two points come together.——*Dr. Chalke*: No, Sir. We really meant the whole question of salary to be brought in at that juncture, I suppose. It does seem a little out of context. Could we dismiss the whole question of income-tax Sir, and go on to the second part?

4505. We have heard a good deal about this income-tax question and we are not going to press you on it.——We are interested naturally in the question of consultants mentioned again in our paragraph 22. As you know, Sir, this is a Guillebaud recommendation and a point I might touch on perhaps is this widening sphere of preventive social medicine today in which the hospitals are much more interested than ever. The whole question of hospital treatment now is bound up with the domiciliary side and local authority services have been brought more and more into the picture. And it seems inevitable the local authority consultant must be in hospitals and he must have the necessary status for that work. That in brief, Sir, is what we mean.

4506. I think I have got your point. Paragraph 15—there you indicate that you are not eligible for a merit award; that is because you have not been doing clinical work?——No, Sir. We make no comment on the desirability for merit awards or the method of giving them. The point we wish to make is that there should be some comparable means of financial reward for distinguished members in our branch of the profesesion, the same as in others, and our view is that we can reach the same end by increasing the salary level proportionately.——*Sir Selwyn Selwyn-Clarke*: May I clear one point, Mr. Chairman, arising out of Sir David's question? It is a fact that a very large number of public health medical officers do clinical work and there are some public health medical officers who are consultants in clinical work. I should not like Sir David to go forward with the idea that public health medical officers do not do clinical work and are therefore not eligible for such additional higher salaries or awards given to our colleagues in other branches of the profession.

4507. Does that refer to part-time? It may refer to part-time, clearly.—— As an instance, the medical officer at Oxford is a oonsultant in infectious diseases and has beds in the hospital at Oxford, dealing with infectious disease patients.

4508. He is a full-time officer?—— Yes, with the City of Oxford Corporation.

4509. *Chairman*: He is also a consultant?——Yes, Sir.

4510. Is he eligible as such for merit award?——No, Sir.—*Dr. Chalke*: A large number of medical officers of health act in this way now as consultants to the groups and hospitals. They have clinical responsibility. I have clinical responsibility in certain respects. I cannot imagine anything more important clinically than the diagnosis of smallpox or anything more important than to be called in to discuss an outbreak of infection, food poisoning and so on. It depends on what we mean by the word clinical. To me the preventing of outbreaks is at least as important as the work of people who say they have clinical responsibilities.

4511. I would like to follow Sir Selwyn's point. Such a medical officer who has beds at his disposal in a hospital has the ultimate responsibility for the individual patients?——Undoubtedly, Sir. He controls and advises on their treatment.

4512. I have not quite understood how it is that he was not, as such, eligible for consideration for a merit award.—— That is one of our contentions, Sir.

4513. *Mr. Bonham-Carter*: He is specifically excluded because he is the medical officer of health?——*Dr. Chalke*: Paid by the local authority.—*Dr. Monro*: There is an arrangement by

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which a medical officer of health may be also employed by Hospital Boards.

4514. *Chairman*: Is he in contract, for instance, with a hospital authority?——I think the arrangement is between his employing authority and the hospital as a rule, but according to which service he gives the most of his time his status and pay is determined. I can quote some medical officers in the far north of Scotland who hold appointments as medical officers of health for very small authorities for less than half their time and and the remainder is devoted to the Hospital Board. They are paid, not as medical officers of health, under Whitley Council Committee C, but as, in this case, senior hospital medical officers.

4515. But if they are paid as consultants for part of their time, presumably they are eligible?——I presume so.

4516. In England, are they not employed by the hospitals on a sessional basis?——*Dr. Tilley*: I think, Sir Harry, there are two distinct arrangements here. One is, as Dr. Monro has said, where an arrangement is entered into that a medical officer of health will work for the hospital authority for less than half of his time. He may continue to receive simply the salary of a medical officer of health and a fraction of his salary is reimbursed to the employing authority. There is a separate system. I have no knowledge how widely the two systems are used; but there is, I know, one instance where the medical officer of health is in direct contract with the Hospital Board for two-elevenths of his time and presumably for that portion is eligible for merit award. That does exist, Sir, but I think it is far from common.

4517. You talked about the pyramid earlier, the one with the London County Council on top. In a sense that gives the competitive opportunity for the good medical officer of health to advance, if you like, from the local authority with a population not exceeding 75,000, up in stages on merit and in competition, to a much bigger position with bigger salary. Is that not so?——That, Sir Harry, is true. One of our difficulties is that the opportunities at the top are very limited. That is something, as far as I can see, we cannot at this moment make any suggestions about. Secondly, the remuneration for those opportunities is very much less than the top opportunities in other branches of the National Health Service. In other words, Sir, were the top of the pyramid to receive remuneration equal to a consultant with a full or top merit award, there would be something comparable which would be an incentive, which would be perhaps going a good way towards making the public health service sufficiently attractive to attract good people.

4518. Has that position altered to the disadvantage of your branch of the profession since before the war or before the National Health Service?——Sir Harry, I can only say I believe that is so. I am unfortunately not able to quote the very top figure, simply because I do not know it, but it is my belief that the medical officer of health for the London County Council, for example, received remuneration which was certainly comparable, and in my own opinion was greater than whole-time consultant people in any hospital services in the country at that time. It is very difficult to get an exact comparison because there was no whole-time paid service with any agreed scale with which this could be compared. I am speaking from memory—the whole-time specialist jobs, I know, in hospital at that time certainly carried a salary less than the medical officer of health of the London County Council. Now that position has been reversed, Sir. I do not know what the arrangement is for merit awards for whole-time consultants—it is not my field—but I imagine the whole-time consultant is entitled to a merit award in some circumstances.

4519. *Sir Hugh Watson*: Before the war there were very few medical whole-time consultants. The majority of consultants before the war were people who were paid little or nothing at all by the hospital, to whom they gave voluntary service; they earned such fees as they could—and some of them very large fees—outside.——Yes, that is true, but there was before the war something with which the medical officer of health could be compared. After 1929 when local authorities were improving their services, authorities like Middlesex, the only one I can quickly remember, did employ whole-time specialists of very high calibre but the medical officer of health received a higher salary.

4520. *Chairman*: Dr. Tilley, you are very anxious for reasons we can understand, to make the comparison between

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the medical officers of health and the consultants. Perhaps we can talk in terms of the general practitioners because there we do know from the Spens Report about the sort of level of the remuneration then and since; and you are competing with other branches of the profession, including the general practitioners for recruits. It would seem from the figures in the County Medical Officers' memorandum that the increases in the remuneration of medical officers are at least of the same order, are they not, as the increases received, as far as we know, by general practitioners under Spens. I do not know whether you know the County Medical Officers' memorandum. I am not looking for the exact comparison but just want to know whether you really can feel, with the different branches of the profession, that things have gone very much to your disadvantage since the war.——*Dr. Tilley*: I am at a disadvantage, Sir Harry, in that I have not the memorandum here. I think that question could well be asked of my colleagues.

4521. I think you have an idea—you are not able to substantiate the figures—that in fact other branches of the profession have gone ahead more quickly than the medical officers.——Yes, Sir. There is a factor that must be borne in mind here. When people came into employment in local government and public health services before 1928 they were entering a pensionable service. There are many factors involved in a man making his decision as to what particular branch or line he is going to take in his career and I think we must accept that the prospect of a pension will attract a large number of very able men who, without the opportunity of a pension in other spheres, would not go there. Today that position no longer holds. The young man qualifying knows that whichever branch of the National Health Service he goes into the question of pension remains the same and therefore that attraction to the public health service has gone. As we feel that the remuneration is also less attractive than the levels of today in the other services, we seriously feel that the future, not so much the present occupants of posts, but the future is very bleak as far as maintaining a good standard in looking after the community health of this country is concerned.

4522. *Sir David Hughes Parry*: May we move on to another matter, paragraph 17 of your memorandum:

> "The salaries of public health medical and dental officers should not be related in any way to those of non-medical officers employed by local authorities."

The word "related" there rather confused me. There must be surely some relation between the salary of the medical officer of health, in a particular place, and the other higher officers?——*Dr. Chalke*: There may be some relation, Sir, but the basis of our argument is that we should first and foremost be paid as doctors. We are first and foremost doctors and our salaries should be relevant to the salaries of other doctors or specialists in all branches of the profession. It is only a secondary point that we happen to be employed by local authorities, but because our branch of medicine is in the field of local authority work we always find ourselves related—as we say in paragraph 20 about the Industrial Court—our salaries are always so closely linked with those of other chief officers that the fact seems to be forgotten that we are primarily doctors and want to be treated as doctors in status and pay.

4523. Paragraph 21—the opening sentence says:

> "Members of the public health service are at a special disadvantage with regard to superannuation benefits. Non-medical local government officers commonly join at a much younger age than is possible for medical officers. . . ."

and so on. You want to establish a relation there, do you not?——Only because it is our last hope, Sir, as it were, in view of the fact that this relationship persists in everything, so surely we can stake our claim for some part of the benefits which other local authority people get. I think that is fair, Sir.

4524. *Chairman*: There must in fact, Dr. Chalke, be a relativity here between you and other doctors since you all come under the same original recruiting and go through the same medical schools at the beginning; but there also must be in fact a relativity among the employees of any large employing body, whether a local authority or a big industrial body.

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You cannot ignore your colleagues in other walks of life, entirely.——No, Sir. We do not quite mean that there should be no relationship at all.

4525. You do say it should not be related in any way.——We mean, Sir, we should not as doctors be prejudiced because non-medical members of local authority staffs get certain salaries. There is always this close linkage, but there obviously must be some connection.

4526. You say status and pay; in what way are you prejudiced in status?——I do not know that we are prejudiced in status. But the medical officer has not the status, for example, or the pay of the Town Clerk. For example in the Industrial Court it was said—I think someone said—"No, we could not possibly have a salary scale of this sort because the medical officer would be getting as much as the Town Clerk." There is always such a close link between the two. We want to be treated as doctors, Sir.

4527. Do you think medical officers of health might have been aware of the position of town clerks when they entered the service?——I am sure they would but they were so interested in preventive medicine and did not look so far ahead, to consider such matters.

4528. Dr. Tilley said they looked so far ahead as to think of a pension.——*Dr. Monro*: Sir, I think there is a point worth bearing in mind, that in 1938 the total personal income, untaxed, in this country was £5,078 million, of which £212 million went to the rates. In 1956 the figure was £17,035 million income, of which £551 million went to rates. If the rates had risen proportionately they would have been £711 million. I think quite frankly that the local authorities, our employers, are slipping and it is not only we who are suffering but the sanitary inspectors, the water engineers, the road surveyors and all the rest. If you go into it you will find similar difficulties of filling vacancies, and incompetent staff. I would like to say this and this to me is frightfully serious: without the sanitary inspector, the water engineer, the drainage engineer and the man who empties the dustbin, 50 million people cannot live in this island.

4529. *Mr. Bonham-Carter*: Dr. Monro, I take your point. What is worrying me a little is that one might find, if we went into a different branch of medicine—the industrial branch—if they argued the same way as you are arguing it might be very strongly to their disadvantage. Would you think the principle you are putting forward on this is really (*a*) a practical one, and (*b*) has some advantage to the profession as a whole? In other words would it not be better to establish a doctor in the community in which he is working, and pay him in accordance with his skill?——*Dr. Monro*: I am not sure I quite grasp that.

4530. You are on this point that you are at a disadvantage by your remuneration being in relation to that of other local government officers. There are other doctors who may have the same situation, that is to say their remuneration is related to people whom you may think it would be to your advantage to be related to. Therefore you might have another branch of the profession arguing entirely against this point of principle. Is not really the answer that it is an exceedingly difficult one to uphold in practice?——*Dr. Tilley*: I am not so sure, Mr. Bonham-Carter. I take your point, and I imagine the group of doctors we may be thinking of must stand in relationship to people with whom they work in an industrial field and their colleagues within the hierarchy of the company, and this may be to their advantage. That does not hold in the public health service. This is not quite a fair thing but it comes to me that this might be regarded as several separate companies working in the same building. The medical officer of health is running his health department. He may have very little contact indeed with the gentleman who is running another department of the local authority. He may not even see him for months on end. He may not be concerned in what happens in a particular department. It seems to me unreal to relate A to B if you are going to recruit into A from a particular field, which is the medical profession. We all feel this very strongly, that our relationship in a public health department is with the doctors who work and live in the community which we serve, the consultants, general practitioners, and the hospitals. Our relationship, Sir, with the other officers, county surveyors and so on, by and large is simply that of a member of the public and we certainly do not feel that parity which may be suggested to you from other sources is at all a proper method of procedure.

4531. It has not been suggested, but experience suggests that it is the employer

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which causes the common binding factor. In groups of people employed by the same person almost inevitably you get a relationship built up through the employer.——*Dr. Chalke*: With the change of structure in 1948 the paradox arose that many persons who were previously deputy medical officers of health now worked under another authority and became consultants. The chest physicians, tuberculosis officers and so on, they were all deputy medical officers of health, and they immediately became consultants because they were employed by another authority. The venereal disease consultant and so on, all benefited by working for another authority. But, more important, although we medical officers of health are actually employed by the local authority, our work has broadened so much, we spend so much time working in the hospitals, in and out of the hospitals with general practitioners. We are in fact primarily doctors, and we should be considered as doctors as part of the medical services of this country.

4532. *Sir David Hughes Parry*: I see the argument all right, but I should have thought the salary of the medical officer of health must have some relation to the salary of the other members of other professions working for the same local authority?——Exactly, in the same way that the salary of a senior medical officer in the Army is in some way related to that of other officers, but he gets a lot more.—*Dr. Hughes*: There is one point, if I may come in. The salaries we are discussing in the main are, if we may use the word, imposed salaries, whereas in industry I imagine that the contracting parties settle it between themselves. There is a national award for National Health Service salaries. I do not think the comparison is quite true.

Mr. Bonham Carter: I wonder if you would argue the other way if it was to your advantage.

4533. *Chairman*: Dr. Chalke, the important thing really is whether you are getting into your branch a fair proportion in quality and in quantity of the whole of the entrants to the medical profession? ——*Dr. Chalke*: Yes.

4534. That is really the point. We have had a good many statements here which perhaps necessarily are rather difficult to substantiate by statistics. Do you think you can do any more than that, or would you prefer it to remain as a generalised thing?——I think we would have to generalise.

4535. You know, Dr. Chalke, of course, that we ourselves have been making a survey of the actual earnings of doctors employed in the National Health Service and of members of many other professions. In your particular branch we know the figures of the scale?——Yes.

4536. But that will show some interesting figures about what is actually happening in the different branches of the profession.——All medical officers of health are not in the National Health Service.

4537. All medical officers are not?—— Not all. Some of them are not—in the metropolitan boroughs, for example.—*Dr. Hughes*: One point on that is if you are going into figures you may consider the question of vacancies and so forth. Establishment is a very different subject. I think it is true to say most of us realise we require more staff than we have got, and it might be we could get authority to increase the establishment, but because of this difficulty we have not pressed for the increase. I think some of us are in that position.

4538. You feel you are under-staffed? ——We are under-staffed, and there is really little point in asking for more staff when we have an awful job in filling satisfactorily the establishment we have got. In my own case, for instance, I think probably, especially with this new work which is coming along on polio vaccination we shall want more staff, but there is little point in asking for an increase in staff when it is difficult to fill the establishment we have got.——*Dr. Chalke*: It is inevitable in my view that this side of preventive medicine will expand and we will require more staff. It is inevitable; more and more people are being treated at home. The domiciliary services will increase, home treatment will increase, and the services we must provide, home helps, health visitors, and so on, must increase, and our link with the hospital will increase. We shall want to expand, and it is doubtful whether we shall get the staff to do it.—*Sir Selwyn Selwyn-Clarke*: Might I add one further point in connection with the seventeenth paragraph of our memorandum? I would like to refer you, Sir, to the memorandum

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from the Local Government Board in 1910, if I may quote from it:

> "The salary offered to a medical officer of health who devotes his whole time to public health work should in the Board's view be sufficient to attract men with good qualifications and to retain their services. The medical officer should not be placed in a position of inferiority in this respect to other medical men in the district. It is not sufficient a medical man is found to accept a salary offered. It is important the salary should be such that it will be worth the while of a capable man to accept it".

We have heard a great deal of criticism against the National Health Service on the grounds that it is made up of three divisions, and those three divisions are lacking in the co-ordination that should exist between them. Some few years ago the late assistant medical officer, the senior administrative officer in Newcastle wrote that one of the chief failures in co-operation between hospital and local authority services lies in the division of the medical profession into two salaried groups of grossly unequal status. Although our Society has nothing to do with the terms and conditions of service —it is outside our purview—we are very concerned with the quality of the recruit to the service. We are very anxious, just as they are in Scotland, not to see this service disrupted with all the consequences to the welfare of the community. I do think that we are entitled to push our claim that we should be regarded as doctors, and have our conditions determined on that basis, and not on what a borough engineer or borough surveyor, or this, that and the other, a layman, receives. Although of course there must be some relativity that should not come into the picture in so far as the determination of the actual remuneration is concerned, in my humble submission.

4539. Most of your members are in fact employed by local authorities?——That is so.

4540. I suppose they put this point to their own employers, to the local authorities?——I would not know whether they have or not.

4541. I suppose, Dr. Chalke, it is quite likely that this point has not escaped your attention on those occasions also, is that right?——*Dr. Chalke*: No.

4542. Are the local authorities satisfied with the quality and quantity of recruits they are getting, or could you not give a generalised picture on this?——I could not say whether they are or not.

4543. But it is very much in their interests to have their services properly run?——We know. Whether our lords and masters know I just do not know.

4544. They are the people whom you would normally tell if you thought you were unable to get, for instance, any applicants for vacanies?——They know that. They do know that because they are the people who make the appointments on our recommendations.

4545. *Sir Hugh Watson*: I suppose Dr. Monro has made it plain to the County Council of Lanarkshire about the situation which exists in getting assistants in his services?——*Dr. Monro*: They knew the difficulties that I had in the first instance, though I must say quite clearly in this that through canvassing the D.P.H. classes just before the "hatch", I secured my requirements without undue difficulty.

4546. *Chairman*: You mean yours is rather one of the more enterprising authorities that gets the degree men?——I would only admit to being lucky.

4547. *Mr. Gunlake*: I wonder if I could ask a question which has been rather worrying me in the last hour. You have said a good deal about your special interest in preventive medicine as a branch of the science, and you have also talked about the difficulty of recruitment into your particular branch of the profession. It might, I think, be superficially inferred from that line of argument that it is the special duty of the local authorities to foster and encourage preventive medicine, but that is not the position at all. Preventive medicine is a thing which is worthy of encouragement of itself, and it should not be the local authorities' specific responsibility to do so. If it is not being encouraged as much as you would like, it might well be the fault of central goverment in general rather than of the local authorities.——*Dr. Chalke*: We do look upon preventive medicine as in the purview of medical officers of health.

4548. That is the point I wanted to bring out, because preventive medicine on the one hand, and social or community medicine on the other, are not the

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same thing, they are not identical.—— They are so bound up one with the other. There is no term which includes the modern concept of promotion of health and positive health, and so on, and all these terms in my view mean more or less the same thing. The point surely is this, that the need for health promotion, call it what you will, social medicine, has widened so much that everybody must take a part; but the medical officer of health seems to be the pivot, the central person, the co-ordinator. In the modern tripartite National Health Service the one person who co-ordinates the work from hospital to general practice, industrial medicine, the one essential person is the medical officer of health, and you must have him. He must co-ordinate all this, he must stimulate health education in the public, and stimulate his colleagues to join together to improve this health promotion which is becoming more important every day—and it is becoming even more important than it has ever been in this automatic and atomic age which is now beginning. The person who must control and co-ordinate all this is the medical officer and the control centre is the public health department.

4549. *Sir Hugh Watson*: Are medical officers of health frequently consulted by general practitioners?——Frequently. That is a very gratifying feature in the last few years. The general practitioners are now coming to regard the public health service as something which is inevitable for the satisfactory carrying out of their practice. Take, for example, the case of health visitors. In certain cases health visitors are seconded to groups of general practitioners to work with them. In other cases there is a shortage of health visitors and they cannot be used more widely, but the general practitioner is coming to look upon the health visitor as his handmaiden, as his almoner who does the social work for him, particularly with the new problem of the aged. He also looks upon the home help service as an essential part of his service; and to co-ordinate all this work and be the link with the hospital, on the geriatric side, the old people, there is the medical officer of health—more so than ever, because public health has changed from the old days of infectious disease prevention, sewers and drains, and so on.

4550. *Mr. Gunlake*: If that be so it does tie the thing to local authorities and their finances. We have the point from Dr. Monro that the whole of the local authority service is a vast depressed area, and a smaller proportion of the net taxable income is going into that particular object than was the case, so the outlook for preventive medicine seems to be pretty poor. That is your contention?——Yes. In fact though we are local authority employees we work more with general practitioners and hospitals than ever before.

4551. *Sir David Hughes Parry*: I wonder if I may ask one question on the Scots memorandum. It is on page 950, under the word "administration". You are obviously pressing a point there. Would you like to state your point? I am not quite certain whether I have got it. Will you place it in opposition to the argument which has been placed that the doctor ought to be paid more because he has got what is described as clinical responsibility for the patient, and that is why he should be paid more than a member of some other profession where that responsibility for life and death does not occur? That has been pressed again and again on us. You are pressing the other side, if I may put it.——*Dr. Monro*: I think the point I want to make is this; I attend to the administration of certain Acts, orders and regulations in the course of my duties. I am chosen as the administrator for that purpose because I have medical skill in the particular brand of medical training. These Acts and orders which I administer relate in fact to the medical needs of people or groups of people. In fact I am really arguing that in the case of the medical officer of health there is no essential difference between clinical medicine and administrative medicine. Does that answer the point?

4552. Yes. In effect you are doing both?——Yes.

4553. *Chairman*: It has been put to us by almost everybody that has appeared before us that their particular body has special reasons why they should be specially rewarded. For instance, the general practitioner says there is this question of night work,

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which I suppose does not apply to medical officers of health as much or as often as to the general practitioner dealing with maternity cases frequently. Is that so, or not?——It depends upon what the person feels about odd cases—infectious cases. They have a bad habit of ringing up after midnight, Sir.

4554. You answer them on the telephone and turn over!——*Dr. Chalke*: The medical officer of health is always on duty.—*Dr. Cookson*: From experience over a good many years now the amount of additional out of hours work in a larger department—I was formerly in a smaller one—is less, and also even in a smaller department it did decrease with the start of the National Health Service. I have done a good deal of general practice in my day, and I do not think that I had any less night work as a medical officer of health than as a general practitioner when I started, but it is less now.

4555. You see you probably know, Dr. Monro, that the medical officers of boarding schools get a reduced capitation fee for two reasons, and one is because they are not on duty for the whole of the population at any time. Are there certain responsibilities that do not come your way?——I would make this point, that the medical officer of health is expected to know the answer, and give it over the telephone. The clinician is at least entitled to examine his patient first.—*Sir Selwyn Selwyn-Clarke*: I would say too that the medical officer of health has a lot of other duties, for example public health education, which he has out of hours, lecturing to voluntary organisations, and others. He also, as has been pointed out, may be called out in connection with infectious disease, poliomyelitis and what not, and he may have a whole series of queries sent to him in connection with, for example, a Windscale incident, the hazards of radiation. He may have to advise where to put a person, an old person who needs hostel accommodation, or home accommodation. He will have very much more work if Parliament agrees to implement the recommendations of the Royal Commission on Mental Illness and Mental Deficienoy. I would like to make the point that the M.O.H. is not a 9 till 5 officer. He is, as the President of the Society pointed out, a man who may be called upon at any moment. I have personal knowledge of members of our Society working all through the weekend over some serious outbreak of infectious disease in the area.

4556. I was rather anxious to get the degree of it. I know the fact is, that as in many other jobs, it does happen that you have au extreme amount of work under pressure and responsibility from time to time, but from the way it has been put to us by the general practitioner we are told that they have more of that than the M.O.H. Is that right? ——*Dr. Tilley*: It must be abundantly plain to the members of the Commission that the medical officer of health is not likely to be called out of bed as often as the man with a large practice, but if you make that comparison we make the comparison also that your medical officer of health in my opinion is as likely to be called out of bed on the same number of occasions as the consultant bacteriologist or pathologist,—*Dr. Hughes*: I would rather like to stress the fact that there is quite a lot of this out of hours work, so to speak, and my impression is that it is growing with one thing and another. Certainly in the last few years I find myself getting busier and busier and taking more work home—not having to get out in the middle of the night, but doing it in late hours.

4557. May I put just one further question on this for relativity? Do I take it from what you say about recruitment, that if by any chance the rest of the medical profession were to get an increase in their pay, for one reason and another, and you did not, the recruitment to your branch would fall off?——*Dr. Chalke*: Yes, Sir, undoubtedly.

4558. But in fact you are really on the whole saying that you ought to catch up?——Yes.

Chairman: The difference is something that will emerge more clearly when we have the real facts.

4559. *Sir David Hughes Parry*: May I add, Sir, and, if I understand your argument, irrespeotive of whether there is any general increase in local government salaries to non-medical men. I took it that was your line of argument? ——Yes.

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4560 *Chairman*: If there happened to be a general increase to local authority non-medical men you would not like to be left out?——No, in other words in presenting our case this morning, we are altruistic in this as an academic body. All we are concerned with is improvement in recruitment and the standard of public health work.

4561. Are there any points that you feel we have not covered adequately bearing in mind all the time that we are not entitled to make any recommendations at all as to what your remuneration should be? We are trying to get a general pioture.——*Sir Selwyn Selwyn-Clarke*: One point I should like to make —perhaps I shall be criticised for making it—I would like to mention the point that the Prime Minister did at one period say that the question of including the public health medical officers in the terms of reference was being considered. I submit the implication is that the Prime Minister and his advisers did feel that the public health medical officers had reason to be dissatisfied with their present status.

4562. I think you must make your own interpretation of what the Prime Minister and his advisers were thinking. I cannot comment on that. Then I think that is all. And now we will have a few words with the Association of County Medical Officers of Health.——*Dr. Chalke*: Thank you very much indeed.

(The witnesses withdrew)

Royal Commission on Doctors' and Dentists' Remuneration

THE ASSOCIATION OF COUNTY MEDICAL OFFICERS OF HEALTH OF ENGLAND AND WALES

I. The membership of the Association of County Medical Officers inoludes all County Medical Officers of England and Wales, and whilst it is understood that doctors employed by local authorities are not amongst those for whom the Royal Commission have been asked to recommend levels of remuneration, this memorandum is submitted on the basis that County Medical Officers are amongst other members of the medical profession on whose remuneration evidence will be received. The Association is submitting this memorandum of evidence because it wishes to draw attention to certain matters concerning the remuneration of County Medical Officers which it believes are not widely appreciated. Taking expenditure of money as a measure of the resources in manpower and the materials deployed in a service and the number of medical staff as an index of the extent of responsibilities exercised, evidence is given later concerning certain representative counties showing the extent of change as between 1938 and 1956—largely in 1945 and 1948. Up till 1948 the remuneration of County Medical Officers was based on the recommendations of the Askwith Committee, first set up in 1929, but on the introduction of the National Health Service this function was undertaken by Committee "C" of the Whitley Councils for the Health Services (Great Britain). The consequence can best be expressed by a statement published in the County Councils Gazette of March, 1956, appearing in a report of a conference of representatives of local authority associations and the London County Council held to discuss a variety of matters concerning negotiating machinery and national awards:—

> "It seems clear now, particularly since the recent Award of the Industrial Court giving to medical officers the same salary increases as were agreed with chief officers of local authorities, that the salary structure of local authority medical officers is tied definitely to the salary structure of other chief officers of local authorities. The conditions of service of medical officers are almost identical and, indeed, the Staff Side of Committee "C" have not been slow in asking for the conditions of service of the A.P.T. Council and the Joint Negotiating Committee for Chief Officers to be applied to doctors as and when changes have taken place. In the view of the Conference, medical officers should take their place alongside their colleagues as local government officers in distinctively local government negotiating machinery."

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With their responsibilities increased it is difficult to establish any logical reason for their remuneration having been dealt with by the Askwith Committee on the basis of comparison with other members of their profession and then after 1948 on the basis of comparison with other Chief Officers in local government who have no part in the National Health Service and who are responsible for the administration and management of services that can be clearly identified as belonging to local government only with practically no association with similar professional activities elsewhere.

II. The Association wishes to place on record the fact that it finds it difficult to understand why the situation arises that the remuneration of County Medical Officers is not being directly considered because the terms of reference of the Commission refer to doctors taking any part in the National Health Service and, unlike any other branch of local government, Local Health Authorities' services provided under Part III of the National Health Service Act are beyond question an integral part of the national services provided under this Act.

Paragraph 4 of the Commission's statement on the 12th April, 1957, seems completely at variance with the terms of reference, which have never been amended. It is clear that Medical Officers of Health employed by County District Councils are not included and the point occurs to the Association that these officers have been confused with Medical Officers of Health to Local Health Authorities.

It will be widely known that in the organisation and management of Local Health Authorities' services, successive Minsters of Health and successive authoritative bodies such as the Guillebaud Committee have repeatedly urged the necessity for the closest possible integration of services as between the three main branches provided under Parts II, III and IV of the Act. The inclusion of County Medical Officers in medical committees associated with Regional Hospital Boards, Hospital Management Committees and Executive Councils is evidence of their share in the services. Since the management of County Council health services under Part III of the National Health Service Act is directed by County Medical Officers, it is ironical that the need for integration should be continually urged by successive Ministers of Health, yet those who must direct its practical application have, for a review of remuneration at least, apparently no part in the National Health Service.

III. Whilst the Association only wishes to offer evidence in respect of the remuneration of County Medical Officers, it is necessary to emphasise that they are doctors responsible for the management and direction of an essential part of the National Health Service; though they are not wholly engaged in seeing patients and are partly, or wholly, occupied in administration, the latter being an essential factor in the Health Service. The doctor's administrative acts are informed and directed by his medical and public health knowledge and experience in a way which is impossible for a lay administrator. Every County Medical Officer must be a registered medical practitioner, which means that he has followed the same training as general practitioners and specialists. In addition, he is obliged also to acquire a Diploma in Public Health or Degree in Sanitary Science and an additional qualification is frequently held. Certain of the statements concerning preventive medicine in the preliminary memorandum of evidence submitted to the Commission by the British Medical Association make clear the importance of services for which County Medical Officers are responsible. Thus:

> *Para. 84*—"Doctors maintained and improved the health and efficiency of the working labour forces. . . . The Health Service is an investment—particularly in respect of the improvement in the health of children".
>
> *Para. 107*—"The first concerns of medicine are maintenance of health, prevention of illness, restoration of the sick".
>
> *Para. 136*—The Consultant has "considerable responsibility for advising on [hospital] administration on matters of policy and development".

The Association realises the dangers of taking statements out of context, but considers it justifiable to use these sentences as a striking illustration of, and indeed as tributes to, the importance of the kind of activities for which County Medical Officers are responsible.

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IV. In the same memorandum the British Medical Association stresses the need to maintain adequate recruitment (Paras. 47 and 91) and remarks on the late age of entry to pension schemes (Para. 93). Both of these conditions apply forcibly to the County Medical Officers and the first is of paramount importance.

Local Authority Services suffer competition from the opportunities, conditions of service and rates of remuneration in the various spheres of medical employment. The Association is convinced that the present condition of local government service is not attractive to young medical practitioners and that as a consequence there will be difficulty in the future in finding enough people of capacity to occupy senior administrative appointments where heavy responsibilities now exist.

The local government services provided under the National Health Service Act, although a separate entity, are themselves an integral part of the National Health Service. All pleas for closer integration and closer association of services must be nullified if the two parts of the service almost entirely engaged in clinical work are, as at present, far more attractive to medical practitioners than the third.

The Association is greatly concerned lest, as a result of the Commission's finding, this position should be made worse. The avoidance of sickness in childhood and the proper care of the aged and sick at home, and well devised health education, are worth a great deal to the community in terms of saving and the prevention of human suffering and distress. It is false economy not to give remuneration commensurate with that of other branches of the profession to those who provide the medical and administrative knowledge, and carry the day to day responsibility for the workings of these services.

V. It is appropriate to refer to the interchange of letters that took place following an interview between the Chairman of the Council of the British Medical Association and the Minister of Health on the 26th April, 1957. In the penultimate paragraphs of the Minister's reply he said—

> "Finally, I have thought, as you asked—about the position of the public health medical officers. I cannot add anything of substance to what I said in my letter of the 17th April on this, but let me repeat that I am sure that any settlement for others, following the Commission's report, could not fail to be taken into account considering the position of these officers, and any claim through the normal machinery would, of necessity, be considered in the light of the report and of any settlement subsequent to it".

VI. The present position arises from the operation of the existing normal machinery of negotiating medical officers of health salaries. With all respect to the Minister, the Association has doubts whether his belief could be borne out in practice if, as the Minister appears to suggest, the existing Whitley Council machinery for determining the salaries of Medical Officers of Health still continues to be used. The Minister of Health is not represented on Whitley Committee C, the negotiating body for the determination of salaries and conditions of service for Medical Officers of Health. Indeed, the salaries of these Medical Officers of Health are derived wholly from rate-borne funds and are not eligible for government grants under the present individual grant system. The British Medical Association representing the medical staff employed in local government service, irrespective of whether they are engaged on National Health Service work or not, has consistently argued in Whitley Committee C that the remuneration of Medical Officers in local government should be based upon the remuneration in other branches of the profession, but the Management Side has held the view that the salaries of County Medical Officers should be related to those paid elsewhere in the local government service.

VII. Two main awards have been made to Medical Officers of Health since 1948 and both derive from findings of Industrial Courts, since agreement could not be reached in Whitley Committee C. On both occasions the Award of the Industrial Court resulted, so far as Medical Officers of Health are concerned, in a scale of salaries being applied on the same basis as applies to other chief officers of the local government service, and the Association believes it to be incontrovertible that the Awards of the Industrial Courts, as part of the Whitley Council negotiating machinery, represent a tacit acceptance of the view of the Management Side.

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VIII. The grounds for the Association's doubts will, therefore, be appreciated since it would seem to follow that if the tenor of the Whitley Council machinery for County Medical Officers has, as the result of two Industrial Court Awards, been to relate their remuneration and conditions of service to those applicable to other chief officers in the service of the County Councils, any financial settlement applicable to general practitioners and hospital staff would have no more bearing in the future than it has in the past in dealing with Local Authority medical staffs. Indeed, on the present basis of Whitley Committee C procedure, the Minister's opinion quoted above is tantamount to saying that the remunerations of chief officers in local government service would need reconsideration on the basis of any settlement that might be made for the majority of the medical profession.

IX. As a matter of history it should be recalled that up to 1948 the remuneration of Medical Officers of Health, and indeed of other Medical Officers employed in the local government service, was based on the recommendation of a Committee presided over by Lord Askwith, which was set up in 1929. This Committee based its recommendations not on the level of salaries obtaining at that time or subsequently in local government service generally, but on the remuneration which might properly be paid for whole-time Medical Officers in local government service. The recommendations were eventually accepted by a large majority of local authorities and in the opinion of the Association were successful in attracting and retaining in the local government service competent and well qualified medical men and women.

It is well to recall that the Committee under the Chairmanship of Lord Askwith was not set up without difficulty and it was the Minister of Health himself who played a great part in bringing together the various bodies who eventually came to agree with him. At a meeting on the 25th April, 1928, when the creation of the Committee was under discussion, the Minister said to the representatives of local authorities:—

> "The interest of the Ministry of Health in this matter lay in the maintenance of an efficient standard of public health service. It was not to support the B.M.A. as such. The Ministry had a further interest—to secure that due economy should be exercised in local government. Therefore, it might be put this way, that the Ministry desired to see the lowest salaries paid that are compatible with the maintenance of an efficient public health service, but was an efficient public health service to be measured only by the efficiency of the Medical Officer in question? The answer to that must necessarily be in the negative because no Medical Officer of a county or district could adequately perform his or her duties, or maintain an efficient public health service, unless they were working in harmonious co-operation with other medical men in the district, and if there were antagonism between the Medical Officer and the general practitioners of the neighbourhood that must necessarily injure the efficiency of the public health service.
>
> It could not be expected that things would always remain where they were 50 years ago, circumstances changed, times changed, conditions changed, and it was necessary to change with them. Nowadays, when rates of remuneration were settled—he was not speaking of public bodies in particular, but of industry or any other body—they were constantly settled by collective bargaining. Every Government since the National Health Insurance Act had had to deal with the medical profession in regard to remuneration under that Act, and throughout had had to deal with them collectively".

The Association would go further and say that in the experience of its members the salaries the Askwith Committee thought appropriate for County Medical Officers were, in general, higher than those paid to other chief officers in the local government service, and that it is true to say that in the majority of cases, after the Clerk of the County Council, the County Medical Officer was the best paid officer in the service of the Authority.

X. The members of the Association are concerned as to the consequences which they believe are arising from the methods whereby the remuneration of the County Medical Officers has been determined since 1948. They do not believe that the services provided by Local Authorities under Part III of the National Health Service

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Act and the allied School Health Service provided under the Education Act of 1944, can be maintained at full efficiency and integrated closely with other branches of the National Health Service on the assumption that in a National Health Service maintained wholly from public funds there can be two grades of medical practitioner, one engaged largely in clinical medicine and the other engaged mainly in the organisation, management and direction of large-scale health services and regarded and paid as local government officers who have received medical training. The local government service can, and does, offer facilities for training in post solicitors, treasurers, engineers and architects but it cannot train medical practitioners, who must spend a considerable number of years in medical schools and, when working in a local health authority's service, must do so in close harmony and association with their professional brethren, whose remuneration is almost entirely now paid from public funds.

XI. The following table gives some statistics concerning the duties and responsibilities of certain County Medical Officers, the basis of comparison being as between the years 1938-39 and 1957-58 :—

		County A	County B	County C	County D
Total Population	1938	1,385,600	749,900	302,600	108,660
	1956	1,601,000	902,200	364,600	127,400
Population for Maternity and Child Welfare Services ...	1938	477,410	442,750	262,813	82,770
	1956	1,601,000	902,200	364,600	127,400
Population for School Health	1938	692,800	474,900	272,230	82,770
	1956	1,601,000	902,200	364,600	127,400
Health Department Staffs:					
Total Whole-time	1938–9	362	195	182	24
	1957	1,704	1,029	341	179
Total Part-time	1938–9	77	169	—	—
	1957	1,825	776	358	124
Total Medical Staff, whole-time	1938–9	30	11	12	4
	1957	51	21	5	4
Women Medical Officers, whole-time	1938–9	6	2	3	1
	1957	35	13	3	3
Whole-time Medical Officers possessing the Diploma in Public Health	1938–9	16	7	4	1
	1957	13	5	3	2
Gross Expenditure on Health Services	1938–9	£407,696	£218,062	£87,106	£36,515
	1957–8	£2,503,740	£1,274,985	£582,330	£182,947
Annual Salaries of Chief Officers of County Council					
County Medical Officer ...	1938–9	£1,600—£1,750	£1,350—£1,500	£1,600	£800—£1,000
	1957–8	£3,180—£3,705	£3,025—£3,390	£2,710—£2,975	£2,070—£2,340
County Treasurer	1938–9	£1,700 (no scale)	£1,250—£1,500	£1,000—£1,300	£950
	1957–8	£3,180—£3,705	£3,075—£3,390	£2,760—£3,025	£1,995—£2,225
County Education Officer ...	1938–9	£1,500—£1,750	£1,250—£1,500	£1,500 (no scale)	£850
	1957–8	£3,180—£3,705	£3,075—£3,390	£2,710—£2,975	£1,995—£2,225

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		County A	County B	County C	County D
County Surveyor	1938–9	£1,500 (no scale)	£1,250—£1,500	£1,300 (no scale)	£950
	1957–8	£3,180—£3,705	£3,075—£3,390	£2,710—£2,975	£1,995—£2,225
County Architect	1938–9	£1,500—£1,600	£1,300	Part-time Architect employed with retaining fee on a per cent. basis	£550
	1957–8	£3,180—£3,705	£2,605—£2,865	£2,340—£2,710	£1,995—£2,225

The differences in the populations of the Maternity and Child Welfare and School Health Service Areas are due to the fact that under the Education Act, 1944, and the National Health Service Act, 1946, those County District Councils responsible for these functions transferred their duties to the County Councils.

Attention is called—

(1) To the increase in the number of whole-time female medical officers, which is due to the difficulty in recruiting men. Many of the women are married and, while appreciating that their valuable services alone enable the work to be maintained, because of their domestic commitments and the absence of the Diploma in Public Health the great majority of them have no intention of accepting the higher posts in the local government service.

(2) The difference in the number of whole-time Medical Officers possessing the Diploma in Public Health. Nothing could show more clearly that the number of those who have this qualification, and are therefore eligible for promotion to appointments as County Medical Officers, has sharply declined in proportion to the number employed and the Association is concerned as to the prospects of future selection for the highest posts, where this qualification is essential, in the medical services of County Councils.

XII. The purpose of this evidence is to set out certain matters in relation to the duties and responsibilities that devolve upon County Medical Officers of Health in England and Wales. It is appreciated that the Commission will be using remuneration standards obtained in many professional fields for the purpose of comparison in discharging the main responsibilities laid upon them in their terms of reference. The Association considers that so far as the present salary position of County Medical Officers is concerned the former basis of comparison no longer exists as between them and their senior colleagues engaged in the fields of general practice and hospital work. Prior to 1948 the County Medical Officer in the local government service was not paid on a basis that was linked with other chief officers. In general, the remuneration that was paid to County Medical Officers was based upon recommendations of the Askwith Committee and those recommendations had no regard to the rates payable to other professional officers in the local government service. The Association has no doubt that in making its recommendation the Askwith Committee took into account the fact that County Medical Officers, like other medical officers in local government service, had benefits of superannuation, sick pay and paid holidays that did not apply to general practitioners and the majority of medical staff working in voluntary hospitals. Two great changes have taken place since 1948; the first is that many of the benefits such as superannuation and sick pay now apply far more widely and the second is that the remuneration of County Medical Officers has, by the operation of Whitley Council machinery, become tied to the salary structure of other chief officers in the local government service. The Association would, therefore, wish to place on record its opinion that any deductions which might be drawn by comparisons as between the remuneration

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received by County Medical Officers and their professional colleagues working in other branches of the National Health Service would be fallacious. The Association considers the continuance of the present Whitley Council arrangements whereby the chief medical officers of County Councils have their basis of remuneration tied to that of other chief officers is, in the long run, inimical to the proper functioning of the National Health Service because it is futile to believe that, in the final analysis, recruitment for higher medical posts in one branch of the medical service can be compared with the recruitment to branches of other local government services.

XIII. Reference has been made to the then Minister of Health's statement to the representatives of local authorities when the Askwith Committee was being formed in 1928 and the Association believes that the final note of this memorandum should be to repeat that what the Minister said then is just as true now. "No medical officer of a County or a District can adequately perform his, or her, duties or maintain an efficient health service unless he is working in harmonious co-operation with other medical men in the district." There cannot be harmonious co-operation between members of the medical profession if members of one section in the National Health Service are regarded, for remuneration purposes, by their employers not as medical men but as local government officers with medical training.

Examination of Witnesses

DR. A. ELLIOTT

DR. J. S. COOKSON

DR. C. D. L. LYCETT

DR. G. RAMAGE

on behalf of the Association of County Medical Officers of England and Wales, *called and examined.*

4563. *Chairman*: Now you have listened to the previous evidence?—— *Dr. Elliott*: Yes.

4564. And we have I imagine covered a very great deal of the ground that is of interest to you, is that so?——Yes, Sir, quite a lot of it is common ground. Of course the point of the Association of County Medical Officers is that it includes all the county medical officers in England and Wales, all of whom are engaged in National Health Service work. All the county medical officers are engaged in National Health Service work, although the purpose of their appointment was required by other legislation. We have touched on the point where we say the whole of our remuneration is at present borne by the rate funds. Some of our county-district colleagues are not employed in the National Health Service as such.

4565. You are employed in the National Health Service and that is one particular reason why you would have hoped that you would have been within our terms of reference?——We would have hoped so. We realise that we are not. 90 per cent of our work is connected with school health and National Health Service work, and the other 10 per cent is in relation to general medical duties, some arising out of other legislation, and some arising out of medical functions relating to our county staffs.

4566. Now on the particular points then that you would wish to make, you give us some very interesting figures on recruitment, which is one of the subjects that seems to us to be most important. Are you having the same kind of difficulties as your colleagues, or is it not so marked?——We have not the same kind of difficulties. In my view—and I have been in the local authority services for nearly 25 years—we can only manage to maintain our services by recruiting women, mainly married women. I am not in any way denigrating their services, but I think we made the point that it is a common experience in counties that we are maintaining our service by employing people who for domestic and other reasons do not wish to seek promotion on the preventive side. This does not make us feel happy about the future administration of local authority services.

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4567. Do you find when there are vacancies to be filled, senior posts, that there are not many people apply for them?——I think, Sir, without a doubt that what was said by the Society is true. Two months ago we advertised a post for what I would call a beginning administrative assistant on my central staff. There is my deputy, three senior assistant specialists and we wanted one below. Now I recall the same post being advertised 20 years before the war started, and then there were 42 applicants and out of a short list of five four have done extremely well since. On this occasion there were ten applicants, two or whom only were worthy of interview, both were in their fifties and neither was suitable because they are older than all the rest of us. We have not been able to fill that post. It is not easy at the present moment, in county councils at least, to find people who have followed the public health service. Clearly we can make it a career on promotion for people who eventually come out at the top, but the stream is not as broad as it was.—*Dr. Ramage*: I agree with that. Also as it is easier for people now to obtain posts, unfortunately there is not the same urge on them to go through the long process of acquiring experience which was described by our colleagues.

4568. Here is perhaps something we did not touch on. To what extent, Dr. Elliott, do medical officers of health when they have reached the senior status as a M.O.H. tend to stay in the same place regardless of the fact that after a very few years they reach the salary ceiling for the post? To what extent do they move on to bigger, and therefore rather more highly paid posts? That may apply more in the towns than in the counties. ——*Dr. Elliott*: We can only speak, and would only wish to speak, on this matter for the counties.

4569. People would go from the county to a town and vice versa?—— Not so much. Since the war I recall only one county medical officer who has come from a town. All the others come from counties, either small counties or from largish counties where they were deputies.

4570. Why is that? I am rather surprised to hear that there is this marked line of differentiation so that on the whole there is not much flow between the counties and boroughs.——*Dr. Ramage*: I think there is more movement at the next lower level of appointment. I can cite myself, for instance; I came from a county borough to my present authority as deputy, and I think that is the experience of a number of authorities. Their deputies may be recruited more widely, but as the administration of the department and other aspects of the work are considerably different in the counties, when it comes to the appointment at the ceiling they tend to take the person who has had an active part in the administration of the county.—*Dr. Lycett*: I think the answer is also in the small number of authorities with large populations, and therefore larger salary scales. Speaking as a medical officer of a medium-sized county, in fact there are very few authorities that offer any real financial inducement owing to the small number of large authorities and to the ways in which the authorities concerned have interpreted this proviso of discretion where there is over 600,000 population.

4571. I am sorry, I have not quite got that point.——It was brought out I think during the evidence of the Society of Medical Officers of Health that authorities with populations of over 600,000 had discretion as to the scales they applied to medical officers of health. Clearly, if they applied their discretion fairly largely there would be scales for the post much above those of the medium authorities, and more incentive to move for promotion. As it is there is not a great deal in it to make up for the cost of moving, and one thing and another.

4572. I think on the figures that you give in your paragraph XI for county medical officers on the whole three out of four of them would seem to be receiving incomes right up to the over 600,000 class. That is right, is it not? ——*Dr. Elliott*: But, Sir, A and B are at discretion.—*Dr. Ramage*: There are a number of counties with populations over 600,000 which have decided that the rate of 400,000 to 600,000 should not be exceeded.

4573. It would mean that just as the borough medical officer from a borough of over 600,000 probably does not apply for any job as a county medical officer, similarly most county medical officers do not really go except to your biggest towns, would that also be true? Once

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you are within one branch or other you stay there?——*Dr. Elliott*: I think that is true. One naturally wishes to stay in a particular branch. Most have started at a fairly early age. If you are in the county you go on for the county, but then you do get applicants for special jobs in the county and county boroughs. An appointments committee of a county borough seeking a medical officer of health would I think rather be inclined to go for a man who had been with a county borough, and the same would apply to the county. The county medical officer in Hampshire appointed recently came from Bournemouth, but by and large I think that is true.

We really are not putting to you our view on salary and fixing of salaries. We realise the point that you are not in that sense the Industrial Disputes Tribunal or the Industrial Court. I think what we want really to say with considerable emphasis, is that the National Health Service is a tripod. There are three branches. It is a comprehensive service. The young practitioner, that is, the doctor in his late twenties, in the case of the hospital service, and in the case of the general practioner field, knows he is going into those fields, he knows he is going to be employed and remunerated as a professional man, as a doctor. When he comes to the third branch of the service there his remuneration is based upon the fact that he is a local government officer first and a doctor second. It is clear therefore that for the young man who had not up to that period had any contact with local government, who has been almost entirely brought up in the hospital field, because that is where his training takes place, the weight is against him to go in for the field where it is made quite plain that he is a local government officer, and not a professional officer which previously he has been treated as.

4574. Is that a new feature, or was it exactly the same in the old days?——No, Sir, it is entirely new since 1948. In fact it did not really apply until the first Industrial Court Award of October 1950. From 1929 until 1948, and until 1950 when we had the carry-over, doctors in the local government service, whether employed in hospitals, mental hospitals or general hospitals, whether employed in the field, were dealt with as doctors. The scales, as we have endeavoured to point out in our memorandum, had no regard to what was paid elsewhere in local government, and it is a point we want to emphasise again. You have already had it, but we are quite unable to see why there should be a link between the salaries of doctors in local government and other non-medical people. It is a matter of administrative convenience that certain services are administered by the elected body, but there is no community of interest between the other county officers and the county medical officer. They are not recruited from the same field. It could well have happened, as in the case of the executive councils in 1948, that the National Health Service Act had set up separate public health boards independent of County Councils and it could not then have been argued that the salaries of doctors employed by public health boards to carry out Part III services should be linked to local government. If they had been surely the hospital services should have been linked to local government too. We have taken the view that it is only a matter of administrative convenience that the Part III health services are administered as part of local government and it does not mean there should be this link of salaries of chief officers.

4575. You do feel that in all there must be some relativity between all kinds of people, whether local government or private industry, or anywhere at all? There must be some sort of relationship between what different people are earning in their grade, and you cannot consider any particular group of people completely separately?——I am rather outside my terms of reference here, but can you make such a broad generalisation? It is a matter of the supply and demand in employment, and so on. What we want to say as an Association is this, that come what may we believe that in the future of the public health service all local government doctors should be treated as doctors throughout, that the position that arose when doctors were paid from public funds, by local authorities from 1929 to 1948 should still continue, and that there should be a separate negotiating machinery. While we naturally hope

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the arguments of two sides, and the Industrial Court decided in favour of the Management Side. The second Industrial Court Award was concerned with cost of living, but the same battle was fought over again with the same result. The principle established in 1950 has not been disturbed, and, of course, the trade union question of reference to the Industrial Disputes Tribunal cannot arise. The situation that we have outlined here whereby since 1950 this tie-up has been between the doctor and the other local government chief officers was not the case from 1929 to 1950.

4586. *Chairman*: Now on a somewhat different point, have you any idea as to the average age at which somebody will achieve the status of county medical officer? I mean in present circumstances, I am not looking back to the past.——There are only 62 counties, 63 counting the L.C.C., which usually counts separately, although Dr. Scott is a member of our Association. It so much depends on the mortality rate, or the retirement rate of existing county medical officers. Frequently the deputy is appointed. It is so fortuitous, I do not think there can be any generalisation.

4587. We have had some figures about the age at which people will achieve consultant status, and so forth, and I am wondering whether in fact most people will achieve full county medical officer status by, for instance, 40 or 50 or not?——*Dr. Ramage*: It would he a lucky man who achieved his chief post at the age of 40. It has happened, hut usually it is about 40 plus.

4588. That is the sort of age?——I think if we take the L.C.C. we would have to say it would he well over 50, but that is perhaps rather exceptional.

4589. *Sir Hugh Watson*: Quite outside this point and separately by itself, is there any interchange between Scotland and England of county medical officers of health?——*Dr. Elliott*: Practically none.—*Dr. Ramage*: I think it is one way.—*Dr. Elliott*: I cannot recall any appointment having heen made of county medical officers from Scotland. In a number of counties medical officers are Scots having started their puhlic health career there.

I would not like the Commission to take entirely the point that you must be at least 40 before you become a county medical officer. I would say the answer is broadly correct. I do not think there is much chance after 50. The authority would look for a younger man.

4590. *Chairman*: I was trying to get an approximate relationship hetween the age at which people normally tend to become consultants, which varies, and that at which they tend to become county medical officers. It is a hit different, but not very much different?——The man who got it at 40 plus would think he was fortunate.

4591. *Sir David Hughes Parry*: I take it the competition for the higher posts is still very keen?——Yes, Sir.

4592. One has to try to look at the structure as well, hecause we have to look over the whole period. I was taking County A in your table and they had in 1938, 16, hut they now have 13 whole time medical officers. How many of those are aspiring to be chief medical officer of health?——I think you have read the wrong figures. At the moment we have 51 whole-time medical officers, as opposed to 30 hefore the war. Taking those in possession of the Diploma in Public Health it was 16 then and 13 now. The point in putting the figures in about the D.P.H. is that only those officers are eligible to become deputies or principals in counties.

4593. That is why I chose them.——Out of that total number, you must relate it to the total, many of those are expecting to stay as they are.

4594. I am looking at those who are really fully qualified to be considered. How many of those can expect to be chief medical officer of health?——County A is my own county, of course.

4595. I did not know that.——*Dr. Ramage*: I think it is true that those who have got their Diploma in Public Health and who have decided to make public health their career, necessarily have a better prospect of the senior post. But I come back to the point again—and I would not like to criticise these men who come in particularly—that it is true that they get the post now with less experience than formerly.—*Dr. Cookson*: Can I make a point here from the point of view of the smaller counties? We have spoken of the counties A, B and C. If you turn to those in county D, I think the effect of the pyramid that we were speaking of

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this morning is even more marked, because although one does not want to make much of the differentiation between the counties A, B, C and D, we do see there a great deal of difference in the remuneration between those in comparable counties D, to the other branches of the profession. If we could take just one example, that in 1938 a county D employed four medical officers more or less of that particular grade, and now they employ one; the other three have gone into other branches of medicine, and there their remuneration is that of consultants. So one has the difficulty of status and remuneration in counties D perhaps rather more marked than in the other ones. Now there are 18 county Ds with a population below 150,000, roughly a third of your total of your 62 counties. There are quite a number of county Ds and very few county As.

4596. *Chairman*: The county D rates before the war were fairly low. They have gone up quite sharply, as have the salary increases.——If we are to consider ourselves as doctors, I would compare myself with the other three doctors who were in county D before the war who are doing similar work now to what they were doing then, and are now paid as consultants with the status of consultants, which is very considerably in excess of the figures which have been given under county D. The status of the county medical officer of the county D if it were in any way connected with remuneration must have dropped substantially. —*Dr. Elliott*: I think Dr. Cookson is probably referring to the position of the old tuberculosis officer who became chest physician in 1948. It did so happen that, dealt with under the old Askwith Agreement, one officer's salary overnight was trebled by changing from one branch of the National Health Service to the other; by going from the local authority service to the public service his salary was trebled overnight.—*Dr. Cookson*: May I add on that that the same applies to the medical superintendent of the mental hospital, and the same applies to the medical superintendent of a general hospital; it is not just the chest physician and the tuberculosis doctor. So far as county D is concerned there were four senior medical officers who were employed in 1938 to 1939; three are now consultants and one is remunerated with the same status as the other chief officers of the local authority. That applies in county D, but does also apply in 17 other counties.

4597. *Mr. Bonham-Carter*: All the witnesses we have heard this morning obviously feel very strongly and deeply about this thing, and therefore there is one last question I want to put about it, this link between the M.O.H. and the other local authority officers. Does that arrangement preclude the doctors' remuneration being on any occasion looked at by itself with a view to making sure that the normal law of supply and demand is being applied?——*Dr. Elliott*: First of all, Sir, of course any chief officer in local government can have a salary scale fixed from a range. There is discretion, as you know, according to the population, so it is theoretically possible for the county medical officer, or for the county treasurer for that matter, to have a different salary, and this appears clear on the basis of the law of supply and demand. If you ask me personally whether local authorities proceed on that basis, in my view they do not.—*Dr. Ramage*: Yes, I should agree with that. The local authorities have worked out this case very forcibly at the Industrial Court, and we feel that they reached by administrative convenience, I might even say by conclave, the classifying of all their heads of departments. I think we find it hard to say in the years 1929 to 1950 that their machinery worked badly just because the medical officer received a little more than the other officers. It was the case in my own county. I first came as deputy in 1940 and succeeded in 1946, and there was a differential in salary there, but the service seemed to work perfectly satisfactorily.

4598. Your argument then is that if they reached a point that there was such a shortage of applicants for the post of county medical officer they would still be so hidebound that they would not adjust the salary accordingly; they are bound by this Industrial Court?——That is the impression one has from the force of the range of arguments that they put forward.—*Dr. Elliott*: At the present moment there is no shortage of county medical officers. All we are saying is that you have, of course, three grades, principal, deputy and senior assistant, and it is our senior assistants where our troubles are coming. We cannot recruit

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the men we want, and our field of recruitment is not as wide as it was 20 years ago.

4599. *Chairman*: I think it was put to us by Dr. Tilley, who is a county medical officer, that one of the important differences was that before the war, yours was the only branch of the medical profession that qualified for pension and superannuation, and that now other branches come into it and that that is a difficulty of recruitment. Would you go all the way with Dr. Tilley on that?——No, Sir, I would not. One has to take superannuation into account, but I do not think a young man of 25 or 26 attaches all that importance to his pension at the age of 65, and I am sure that women do not attach all that importance to it, because I presume they hope they are going to get married, and the pension does not matter. We believe, again coming back to the same point, and you must be tired of hearing it, that from 1929 up to 1948 practically the whole of the whole-time salaried medical profession were in local government service, either outside or inside the hospitals, but in local government service. Now the State has become the paymaster and there is a difference between the three branches of the service in the attitude of the paymaster to the person who receives the pay. In two cases, in two branches of the service the payment is made to the doctors as doctors, and in the other one it is not, they are secondly doctors.—*Dr. Ramage*: I think if I may comment on that, we do not want to be drawn too far on this question of salaries, but we wish to be doctors come what may, whether up or down. When we make a comparison of doctors with people in local authority work before the war and make the comparison now, the fact that the other doctors may receive the advantages of superannuation and so on should be borne in mind. In reality the doctors in local government prior to the war were better off than appeared from just looking straight at their salaries, and that advantage has gone.

4600. I do not think I have any more questions. Do you feel you have made that point sufficiently?——I think we have made it, thank you very much.

4601. I rather understand you want to be thought of as doctors! (*Laughter.*) Then I think that concludes the meeting unless you have any other point?——*Dr. Elliott*: We wish to thank the Commission very much for hearing us separately. We do very much appreciate it.

(*The witnesses withdrew.*)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

19

Nineteenth Day, Thursday, 15th May, 1958

WITNESSES

Medical Research Council

Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom

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Witnesses

MEDICAL RESEARCH COUNCIL

SIR HAROLD HIMSWORTH, K.C.B., F.R.S., M.D., M.B., F.R.C.P., M.R.C.S. — Pages 982–1008, Questions 4602–4690

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Pages 1009–1032, Questions 4691–4809

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

NINETEENTH DAY

Thursday, 15th May, 1958

SIR HARRY PILKINGTON (*Chairman*)

MR. J. H. GUNLAKE, C.B.E., F.I.A., F.S.S.

MR. I. D. MCINTOSH, M.A.

SIR DAVID HUGHES PARRY, Q.C.

PROFESSOR JOHN JEWKES, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence to all representative medical and other interested organisations.

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

(i) The quality and quantity of recruits (*a*) offering themselves and (*b*) accepted for training as medical students.

(ii) The quantity and quality of newly qualified doctors.

(iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.

(iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).

(v) The position and prospects of a newly qualified doctor.

(vi) Any trend to excessive resort to certain branches of the profession at the cost of others.

(vii) The relative advantages and disadvantages, financial and otherwise, of service as:—

(*a*) a principal in single-handed general practice,

(*b*) a partner in general practice,

(*c*) a whole-time consultant in the National Health Service,

(*d*) a part-time consultant with the maximum number of sessions,

(*e*) a part-time consultant with only a few sessions,

(*f*) a Senior Hospital Medical Officer,

(*g*) a doctor in any other sort of practice or employment.

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(viii) The difficulties encountered by members of the registrar grades.

(ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.

(x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.

(xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.

(xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.

(xiii) Any anomalies in the methods of payment of any branch of the profession, e.g.maldistribution as opposed to wrong total volume.

(xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.

(xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.

(xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.

(xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.

(xviii) Specific proposals for medical remuneration.

(xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.

(xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.

(xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

MEMORANDUM FROM MEDICAL RESEARCH COUNCIL

Abstract

A. In organising for the present and future needs of medicine, it should be recognised that the concern is not with a single discipline, but with a series of interrelated subjects, all of which must be adequately provided for as each is indispensable to the final practical outcome. To this end, the system of remuneration of those engaged in the service of medicine—and particularly in medical research where the medicine of the future is taking shape—should be such as to impose no artificial obstacle to the natural distribution of the available talent between its different branches as need and opportunity develop.

The Medical Research Council, as the body primarily responsible for medical research in this country, feel that the present system of remuneration imposes such obstacles, and that these, by their continued operation, are likely to have an increasingly deleterious effect upon the development of medicine in this country.

B. The basic remuneration of consultants and of research workers in all branches of medicine is approximately the same, but, in certain branches, workers receive additional remuneration in the form of a Distinction Award. The total remuneration of these latter can thereby be raised to almost double that of the former.

C. Were this differentiation related to the developing needs of medicine or to the distinction of the workers concerned, its inevitable influence upon the distribution of the available effort and talent might be justified. But it is not. Thus out of the 64 medical research workers now in post who are Fellows of the Royal Society, 54 are

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ineligible for the higher rate of remuneration ; of the four living British Nobel Prize-winners in medicine (including one who was awarded the prize jointly for the introduction of penicillin) none are, or, if in post, would have been, eligible. Further, as all branches of medicine merge imperceptibly into each other, there is no clear and indisputable point in the nature of the work at which the present gross differences in remuneration could be imposed without creating (as they have done) disturbing anomalies.

D. The Medical Research Council are not opposed to the system of Distinction Awards in principle ; but what they must oppose is the restriction of eligibility for such awards to a particular section of medicine to the neglect of its other branches. They feel, therefore, that earnest consideration should be given to the possibility of extending eligibility for Distinction Awards to all workers in the field of medical research. In terms of numbers the problem is small ; in principle it has already been partly solved in Northern Ireland.

ROYAL COMMISSION ON DOCTORS AND DENTISTS REMUNERATION

Memorandum from Medical Research Council

REMUNERATION AND THE DEVELOPMENT OF MEDICINE
THE EFFECTS OF THE DISTINCTION AWARD SYSTEM

1. During the last hundred years, medical knowledge has advanced more than in any other period of history. Inevitably, in the process, it has become increasingly complex and the natural result has been increasing specialisation and the extension of interest into ever widening fields of contiguous knowledge. This trend will continue. In organising for the present and future needs of medicine it is, therefore, necessary to recognise that we are concerned, not with a single discipline, but with a series of interrelated studies, each indispensable to the final practical outcome. Thus, even when attention is specifically turned to that part of medicine which is directly concerned with the care of the sick, the larger structure of modern medicine needs to be kept in mind so that suitable provision is made for each of its components to make its own essential contribution.

2. Adjustments of and additions to medical organisation are particularly necessary at the growing edge of medical knowledge, that is, in the research field; and it is here that the full complexity of modern medicine is most apparent. Today, behind any new measure which finds its expression in policy or practice lie many diverse contributions, not all of which are such that their essential nature, or even their existence, is readily appreciated. Perhaps no single event has more transformed medical practice than the discovery of antibiotics ; yet the introduction of penicillin into clinical medicine was made possible only by the work of pathologists, bacteriologists, biochemists, pharmacologists, toxicologists and organic chemists. Similarly, our present understanding of many illnesses and their rational management is based upon physiology and biochemistry ; radiotherapy is completely dependent on medical physics and radiobiology ; the control of malaria rests upon the contributions of entomologists, toxicologists and chemotherapists. These examples could be multiplied, but they suffice to show that both the progress of medicine and the efficiency ultimately attainable in practice are today largely dependent upon the maintenance and development of a wide-ranging organisation of men with interlocking and complementary activities.

Any system of organisation which failed to provide for this, or placed obstacles in the way of its development, would rightly give rise to grave concern. It is because the Medical Research Council, as the body primarily responsible for medical research in this country, feel that the present policy regarding remuneration of those engaged in the service of medicine threatens harm to medical research, that they have sought this opportunity of laying their views before the Royal Commission on Doctors' and Dentists' Remuneration. They particularly refer to one feature of the present scheme of remuneration, the system of Distinction Awards by which salaries in some branches are augmented far beyond those in others.

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3. The ability to advance knowledge is not common and the total research talent available in the medical field will always he limited. The dependence of medicine for its development on research makes it all the more important to ensure that those capable of original investigation should he employed to the best effect. If the medical profession is so organised as to provide opportunities for research, the potential original investigator will naturally find his way into a research career; his strong desire to follow his own hent in advancing knowledge may even lead him to take up such a career at some financial disadvantage. If however the dice are too heavily loaded economically against the research worker, many will hesitate to accept what must be regarded as an unreasonable sacrifice of their own interests, and even more, the interests of their families. The restriction of eligibility for Distinction Awards to one section of those engaged in the service of medicine has had the result that men in some branches of medicine, and particularly in laboratory research, find themselves in receipt of little more than half the remuneration of those in other branches.

4. Inevitably, disparity in remuneration of this degree has led to discontent, particularly as all remuneration comes eventually from the same source, the public funds. Since medically qualified research workers are recruited from the same manpower pool as those aiming at consultant and specialist posts, the continued operation of the Distinction Award system in its present form is bound to hinder recruitment to certain essential branches of medicine, and so ultimately, by leading to maldistribution of ability, to retard the advance of the whole. To appreciate the full effects of the anomalies created hy this system, it is necessary to examine it in more detail.

Before doing this, however, it is necessary to draw attention to a point which might otherwise lead to misconception. The salary structure and grading of posts in the Medical Research Council's service are deliberately aligned to those in the Universities, and the same broad division of the subject into clinical, paraclinical and preclinical is followed by both. The Universities have, however, other responsibilities than the development of medicine, and it should not he thought that the Council, in presenting the matter as they know it, seek in any way to speak for the Universities.

The System of Distinction Awards

5. There are three grades of Distinction Award: Grade A, £2,500 per annum; Grade B, £1,500 per annum; Grade C, £500 per annum. Of those eligible, 4 per cent. receive Grade A awards; 10 per cent. Grade B, and 20 per cent. Grade C.

The Distinction Award is an item of remuneration, paid in addition to the basic salary, and counts equally with this for such purposes as pension.

To a person, judged eligible, who receives his basic salary from some source other than the National Health Service (such as a University Professor or Medical Research Council employee in certain branches of medicine) a Distinction Award is payable on the strength of an honorary contract with that Service.

The basic salaries of consultants in the N.H.S., and of academic and research workers in senior clinical posts, all have the same upper value, although progress up the scale for consultants and specialists is hy automatic increments whilst progress up the academic and research scale is by separate acts of promotion. The basic salaries for non-clinical academic and research posts have a lower upper limit: £3,000 p.a. as against £3,250.

The proportion of a Distinction Award payable to any individual is determined on the basis of the actual time spent in the particular activities deemed to qualify him for such an award. Thus a whole-time employee in the N.H.S. receives the whole award; a part-time employee a corresponding fraction. From the start of the N.H.S. in July, 1948, until March, 1955, whole-time senior workers in the Universities, and with the Medical Research Council in certain branches, were paid the whole of an Award. Thereafter, they were paid a fraction according to the time spent in certain activities. This ranged from the whole Award if they spent 21 or more hours a week, to 3/20 if less than 3½ hours.

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6. Distinction Awards are conferred by the Ministry of Health on the recommendation of a special national Committee which includes representatives of the Royal Colleges and Scottish Royal Corporations, and one representative each of the Universities and the Medical Research Council.

The grounds for conferring such an Award are: ". . . to recognise special contributions to medicine in the field of research or otherwise, exceptional ability or any outstanding professional work (other than administrative) . . ." (Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists, p. 11.)

7. The definition of the criterion for eligibility for a Distinction Award has not been easy. The terms of reference of the Interdepartmental Committee which made the original recommendation necessarily limited them to considering only a section of those engaged in the service of medicine: ". . . registered medical practitioners engaged in the different branches of consultant or specialist practice in any publicly organised hospital or specialist service." Such services being concerned with the day-to-day care of patients, the recommendations were, understandably, interpreted as being restricted to those directly engaged in such work; that is, those who had what is called clinical responsibility.

It has, however, proved difficult to draw a line on this basis. Medicine is one and its different branches merge imperceptibly: the clinical subjects proper, such as internal medicine and surgery, merge into the so-called "paraclinical" subjects such as pathology, bacteriology and pathological chemistry, and these in turn into the "preclinical" subjects such as physiology, biochemistry and pharmacology. The result has been that, in practice, eligibility has been conceded to some, but not all, holders of certain paraclinical posts (and in one part of the country persons in preclinical posts as well), but has been denied to others engaged in similar work.

The Present Working of the Distinction Awards System

8. Of the considerations to be taken into account when making a recommendation for a Distinction Award, the first to be mentioned is "special contributions to medicine in the field of research".

To the best of our knowledge, this consideration has been given full weight by the national Committee recommending such awards, in so far as they were able to do so within the restrictions on eligibility to which reference has been made. But if attention is directed to the larger picture of medicine, the result is disquieting.

Taking as the whole scope of medicine the variety of studies comprised in the medical faculty of a University or supported by the Medical Research Council, the result is as follows:—

Of the 64 Fellows of the Royal Society engaged in such studies and at present in post, 54 are ineligible for Distinction Awards. Of the four living British Nobel Prizewinners in medicine (including one who received the award jointly for the introduction of penicillin), all are (or if in post would have been) ineligible.

9. Mention has been made (para. 6) of the difficulty of confining eligibility for Distinction Awards to those directly responsible for the day-to-day care of patients, so that, in practice, it has been conceded that some but not all holders of paraclinical posts should be eligible. This has led to disturbing anomalies.

The concession regarding holders of posts in paraclinical subjects has primarily depended upon the man's place of work. If he were working in an institution, such as a medical school, related to a hospital, it was usually found possible to arrange that he be made an honorary consultant to the hospital, and thus become eligible for a Distinction Award. If, however, he were working in an institution unrelated to a hospital, then, irrespective of the nature of his work, it was not possible to make such an arrangement and he remained ineligible.

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This situation has led to considerable practical difficulty. In the case of the Medical Research Council, whose staff are placed in many different institutions, gross differences in remuneration may occur between different individuals which are related neither to the merit nor the nature of their work, but to where they happen to be placed. Instances have occurred in which it has proved impossible to transfer a man to a more responsible job, even when both are under the Council's direction, because to do so would have meant changing his place of work from one in which he was eligible to one in which he was ineligible for a Distinction Award.

10. Although the first Distinction Awards were paid retrospectively to July, 1948, the awards were actually made only in 1950. The seven years that have passed since then hardly allow time for the full effect on recruitment to the non-clinical branches of medicine to be felt. Further, the Medical Research Council are particularly handicapped in demonstrating this effect, for their staff is relatively small, its main expansion has occurred since the war, and recruitment to it is by invitation rather than advertisement. Nevertheless, in their oldest and largest Institute—the National Institute for Medical Research—the consequence is becoming apparent. For example, in the important Division of Physiology and Pharmacology in 1948-49, 6 out of its 7 members were medically qualified; now the corresponding figures are 4 out of 8. In the Division of Biochemistry there is only one medically qualified worker out of a total of 18.

To some extent this situation may reflect a drift of interest in research towards more clinical studies; but, even if this be so, it is all the more important not to accelerate artificially the depletion of the essential preclinical and paraclinical fields.

The effects of the Awards system on recruitment of junior staff will necessarily take time to become fully manifest; but before then a serious situation is likely to have developed at a more senior level. It is not usually until the middle thirties that a research worker acquires the experience and develops the powers required to fit him for a key post; and it is usually at that time the family responsibilities begin to press. The Council are well aware of the personal pressure which some of these valuable men are under to move to posts elsewhere which, although carrying less responsibility, would gain them eligibility for a Distinction Award. Up to the present the Council has been singularly fortunate in losing so few senior men from key posts on the Institute's staff; but this cannot be expected to continue, and in the cases in which it has occurred the difficulty of replacement has given an indication of the serious situation to be expected.

After a careful consideration of the position, the Director of the National Institute for Medical Research has felt bound to warn the Council that they are now facing a grave situation. The Council agree with him; for it is generally recognised that if medical research is to derive its chief inspiration from medical problems it must in all branches, including the paraclinical and preclinical, include among its workers a substantial proportion with medical qualifications.

Extension of the System of Distinction Awards

11. The Council are not opposed in principle to the system of Distinction Awards. They consider it in the best interests of medical progress that superior merit should receive larger remuneration. What they must oppose is the restriction of Distinction Awards to a section of medicine in such a way as to threaten the natural development of the whole and so to jeopardize continued progress. The Council feel, therefore, that earnest consideration should be given to the possibility of extending eligibility for Distinction Awards to all workers in the field of medical research.

This proposal is not new, but it has gained force with the passage of time. Various objections have been urged against it, and these need brief consideration.

Objections which have been raised to Extending the Awards System

12. It has been contended that, even when consideration is confined to the present restricted eligibility, the factors to be taken into account when making awards are

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sufficiently complicated, and that to exend the system to cover the whole paraclinical and preclinical fields would make it unworkahle.

Since 1948, in Northern Ireland, Distinction Awards have heen available to holders of paraclinical and of preclinical posts if medically qualified.

13. It is said that it would be too expensive to extend the Awards system.

In 1955, the numher of consultants and specialists in the N.H.S. eligihle for Distinction Awards was 6,650. The total number of persons in the para- and preclinical departments of the Medical Research Council who would be sufficiently senior to be considered for such Awards, if the scheme were extended, is about 100.*

14. It has heen claimed that the strain of responsibility involved in taking care of patients entitles those with such responsibility to receive substantially larger remuneration.

While respecting this view, we feel that it may be overstressed. The ability of a man to support any particular responsibility depends to a large extent on his training. A trained consultant who may have no hesitation in handling a medical emergency, might well shrink from the responsibility of passing as safe for issue a vaccine that is to be given to thousands of people. Further, the question of differences in responsibility hetween the eligible and the ineligible in the paraclinical field does not arise.

15. The most difficult question that has to be faced is whether persons working in the medical field who are not medically qualified should be eligible for Distinction Awards.

For many years now, medicine has required the help of men whose initial training was in other disciplines and, in the process, has changed them into a hody of specialised workers peculiarly identified with its needs. Indeed, a substantial factor in its recent spectacular progress has heen this assimilation of other disciplines and their modification to its own purposes. In some fields—for example in medical physics—only rarely could a medical man acquire the necessary depth of specialised knowledge. In others, the overlap with traditional medical knowledge is more marked; and in some complete interchange is possible.

Although the Council agree that the paraclinical and preclinical departments of medicine can very profitahly, and indeed, must now include, a considerable body of non-medically qualified scientists, they are persuaded that these departments, in the interests of their continued orientation to medicine, need to include a substantial proportion of those with medical qualifications. Both are necessary; one is the complement of the other. Further, they would willingly accept a non-medically qualified scientist as head of a department of physiology or bacteriology, provided that not all such departments were so staffed. But it would clearly be impossible to alter the salary of such posts according to whether the particular occupant has or has not previously taken a medical degree. The only possihle solution, when this matter was debated in relation to the basic salary, was to pay the rate for the joh. At the level of posts of this seniority in research it is proven merit, not formal qualifications, that is decisive. This is the principle upon which the remuneration of the Council's own staff is constructed. It follows, therefore, that in their opinion, if the man's contributions to medicine would normally entitle them to consideration for a merit award, the fact that he has not previously taken a medical degree should not exclude him.

16. It is, therefore, the considered view of the Medical Research Council that, if the inequitable salary structure of medicine, arising from the present system of Distinction Awards, is allowed to continue, it cannot fail to have deleterious effects upon the development of medicine in this country. In their view, measures to remedy this situation, hefore its full effects have become evident, require urgent consideration. An essential feature of any such measure would he that it took

* [The corresponding number in all Universities would be, according to our information, about 300.]

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account not merely of one section of medicine, but of medicine as a whole, by ensuring that the financial inducements in all branches were sufficiently similar to allow available ability to distribute itself according to natural need and interest. If a system of Distinction Awards is to be retained but the artificial effects of the present system removed, then there would seem no alternative but to extend eligibility for such awards to those in all the branches of medical research.

November, 1957.

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

Evidence submitted by the Medically-qualified Staff of the National Institute for Medical Research (Medical Research Council) London

PART I

OUTLINE OF DISCREPANCY IN REMUNERATION

1. The terms of reference of the Royal Commission include a request that the remuneration of doctors within the National Health Service be compared with that of doctors in other fields. One such comparison, which brings out a gross discrepancy, is outlined below.

Personnel Involved

2. The group of doctors outside the National Health Service with which we are concerned in making this comparison, is a very small one, estimated at about 400 in all. The group includes senior lecturers, readers and professors in the preclinical teaching departments of the Universities together with those of equivalent seniority engaged in whole-time medical research, mainly with the Medical Research Council. These two broad categories are linked to form one coherent group because, at present, the M.R.C. salary scales are based upon the scales pertaining in corresponding University departments.

Status of Personnel in relation to N.H.S. consultants

3. To compare this group of 400 medically-qualified men and women with any particular group of doctors employed in the N.H.S. is difficult. We believe, however, that there are many points of close resemblance between this group and the consultant group in the N.H.S., such as:

(*a*) entry to both is restricted to those of high academic achievement;

(*b*) seniority in both is the result of a long period of postgraduate training and apprenticeship;

(*c*) many members of both groups are concerned with the teaching of medical students. The similar responsibilities of the two groups for the continued production of an informed medical profession is thus clear;

(*d*) both groups play an important part in advancing the frontiers of medical knowledge, the preclinical teacher and whole-time research worker in the laboratory, the consultant in the clinic.

4. We hold that neither group predominates in importance, either in teaching or in research; and that the two groups are recruited from the same raw material and are essentially equal in status, ability, qualifications and experience.

Remuneration of Personnel in relation to N.H.S. consultants

5. Notwithstanding the relative comparability of the two groups, there is, at the moment, a wide discrepancy in their financial rewards. This is best illustrated by the Table overleaf, which is based on the following considerations:—

(a) *Senior Research Worker or Preclinical University Teacher*

A typical senior research worker or preclinical University teacher may expect to be appointed as a senior lecturer or reader (or its equivalent in

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whole-time research) at the age of about 35. He will earn a salary of about £1,700, which will rise by annual increments of £100 to some £2,200. He has no guarantee that he will rise above this salary. Indeed, any further increase will be contingent upon appointment to a Chair (or its equivalent in whole-time research). If the average age for appointment to a Chair (or its equivalent) is taken as 42, and we make the assumption, which is broadly correct, that at any one time one-third of the group of 400 occupy University Chairs or equivalent appointments, then the chances of our typical worker being appointed to such a post before retirement are somewhat less than 50 per cent.

(b) *Consultant*

A typical consultant may expect to be appointed at the age of about 38. He will receive a salary of approximately £2,600 which will rise by annual increments of £125 to £3,250. Once appointed a consultant, he is *certain* to reach this salary if he remains in the service. Furthermore, the maximum salary of £3,250 is by no means the maximum of his possible total remuneration since he has a very good chance of acquiring a distinction award. We have no information about the age distribution of consultants at the time they are given distinction awards. We have therefore made an assumption, which is not necessarily true but which seems not unlikely. We have assumed that, on the average, a distinction award (considering all grades together) is given to a man in mid-career. This implies that, since 34 per cent. of consultants are in receipt of distinction awards at any one time, the chances of our typical consultant acquiring an award before he retires are twice this, namely, 68 per cent. This two-fold increase will, of course, tend to be greater for "A" awards which are probably usually given to older men and less for "C" awards.

6. On the basis of these examples, we can calculate the probability of a typical member of each group attaining a final total remuneration (before he retires) of various amounts; the results of such calculations are given in Table I.

TABLE I

Total Remuneration*	Percentage chance of achieving such remuneration or better	
	Consultant	Senior Medically-Qualified Research Worker or Pre-clinical University teacher
£2,250	—	100
£3,000	—	50
£3,250	100	0
£3,750 (Salary + C award)	68	—
£4,500 (Salary + B award)	28	—
£5,500 (Salary + A award)	8	—

*Total remuneration takes no account of children's allowances (£50/child) payable by Universities and the Medical Research Council but not by the N.H.S.; nor of other fees and emoluments payable to consultants by the N.H.S. but not payable by the Universities or the Medical Research Council.

Patient Responsibility Differential

7. It seems clear that this disparity in total earning capacity cannot be dismissed as trivial. It is also evident that it does not reflect differences in basic ability. A difference in respect of patient responsibility is admitted, but cannot be held to justify a discrepancy of this magnitude. (The B.M.A. some time ago suggested a differential of 10 per cent. in respect of patient responsibility.)

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Effect of Discrepancy on Pensions

8. Much of the difference in total earning power is, of course, only apparent in view of the toll taken by surtax on the larger salaries, and we have calculated typical figures for net income (see Table II). But the distinction awards count towards superannuation; pensions bear proportionately less tax; and the discrepancy in pension is therefore relatively greater. The figures given in Table II illustrate this, which is—we consider—an aspect to which too little attention has been paid in the past.

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TABLE II

Effect of Distinction Awards on Net Incomes and Net Pensions

Remuneration	Gross Income (no children)	Net Income (2 children)	Per cent increase in net income due to award	Gross Pension	Net Pension (no children)	Per cent increase in net pension due to award	Per cent of group drawing net pension
Salary (Non-professorial)	2,250	1,775	—	1,125*	925	—	50 } 100
Salary (Professorial)	3,000	2,225	—	1,500*	1,175	—	50 }
Salary (Consultant)	3,250	2,375	—	1,625	1,250	—	32 } 100
Salary + C Award	3,750	2,600	10	1,875	1,425	14	40 }
Salary + B Award	4,500	2,950	24	2,250	1,650	32	20 }
Salary + A Award	5,500	3,325	40	2,750	1,950	56	8 }

* These figures are not based upon F.S.S.U. benefits which vary for each individual; but are calculations of the equivalent that would be obtained were the same scheme operated in the Universities and the Medical Research Council as in the National Health Service.

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T. W. OSBORN.
J. PEPYS.
R. GOLDSMITH.
R. H. FOX.
H. W. BUNGIE.
T. S. L. BESWICK.
L. WEISS.
J. H. HUMPHREY.
J. S. PORTERFIELD.
H. G. PEREIRA.
J. D. FULTON.
M. R. POLLOCK.
D. I. MAGRATH.
A. MCPHERSON.
J. A. ARMSTRONG.
C. P. FARTHING.
B. BALFOUR.
A. ISAACS.
JANET S. F. NIVEN.
P. H. A. SNEATH.
AUDREY U. SMITH.
B. M. WRIGHT.

Total medically-qualified staff 42
Signatures (two persons abroad) 38

Date: 20*th February*, 1958.

Examination of Witness

SIR HAROLD HIMSWORTH, on behalf of the Medical Research Council,

Called and Examined

4602. *Chairman*: Sir Harold, we are very grateful to you for coming here, and I hope we shall not need to be very long with you, because in the whole of our very wide range of problems you concentrate on one particular and isolated aspect. You probably do know that this is a public session and that anything you say is liable to be reported, and no doubt you will bear that in mind. ——*Sir Harold Himsworth*: Yes, I understand that.

4603. We have asked Sir David Hughes Parry, whom I think you already know, to prepare most of the questions we want to ask you, but would you mind first,—since the memorandum which the M.R.C. have put in will be printed along with your evidence—giving us an outline of what the Medical Research Council is, how it is constructed and what are its functions, authority and so on?——The Medical Research Council is a body established under the Privy Council. There is a committee of medical research of the Privy Council, of which the Lord President is chairman, and it is to that committee of the Privy Council that the Medical Research Council is responsible. It consists of twelve members, of which three are elected in respect of their non-scientific qualifications, one of whom must be a member of the House of Lords, one of the Commons and one other distinguished person. The rest, the other nine, are scientific members; they are appointed by this committee of the Privy Council, but the nomination of the scientific members is made by the Council itself after consultation with the President of the Royal Society. The remit of the M.R.C. has always been interpreted very widely. It is concerned not only with disease but with health and all the basic studies that go to the understanding of normal human life, as well as to pathological processes. It therefore ranges in its remit from studies like the structure of biological molecules, through chemistry, biochemistry, anatomy, physiology, bacteriology, and so on, into the clinical field, and includes studies in all the clinical specialties. It derives its money from two sources: far and away the major part is a grant in aid from the Government; but it also holds private funds left to it in the form of legacies, covenants and so on, which it is free to dispense. That is roughly its constitution.

4604. And how many people does it employ?——It employs directly on its staff, in the scientifically qualified staff, over 600—that is, directly under its own employ. With technicians, clinical staff, supporting staff and so on, we are getting well up to 2,500.

4605. And are they all whole-time employees?——Those I have mentioned, yes. A very small number are part-time; for instance, we might have a man who for half his time is positioned in the

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National Health Service and the other part of his time is on our staff.

4606. *Sir David Hughes Parry*: When you say "qualified", you mean they are qualified medically?——No, I meant that they have a university degree and are what we call our scientific and medical staff; I was putting them both together.

4607. I wonder if you could give us an estimate of the numbers who are medically qualified among the 600 qualified?——Roughly just about two-thirds, 60 per cent. are non-medically qualified, but that includes of course, as is essential with medicine nowadays, a large number of juniors who are operating these highly complicated machines and methods of estimation which are necessary: for instance, a physician nowadays in many fields hardly seems to be able to function unless he has a chemist attached to him.

4608. Could I pursue this further? Are the 600 qualified people all working in one centre, or are they working at different centres?——We have only one large research institute, the National Institute for Medical Research, at Mill Hill, associated with a building at Hampstead. The vast majority are in what we call research units and groups. Most of those, in fact with one or two exceptions, are placed as guests either in teaching hospitals or universities, a few are in non-teaching hospitals; that is our main method of distribution. In addition we have a few people whom we call members of the external staff, who are solitary persons, that is, they are not in one of our departments; they may be operating in some field where the lone wolf is required. More often they are operating in a university department, because the professor has been very anxious not to lose them and he has not had the money to keep them on his staff, and he has asked us to help him out.

Sir David Hughes Parry: Thank you very much, that is of great interest to us.

4609. *Mr. Gunlake*: Is your field of activity confined to the United Kingdom, or does it extend to the Commonwealth or to foreign countries?——We have no geographical limitation. But for the purpose of this discussion I have confined myself to the United Kingdom, although we have for instance a research unit in East Africa, one in West Africa, one in the Caribbean; we recently had one in Jordan, and we operated in Egypt, and we are now operating through the W.H.O. in Madras in India, and of course we have frequent contacts with the Dominions.

4610. *Chairman*: But those units are, as it were, units sent out from here?——Yes.

4611. And paid from here by the Council—from the Treasury? From your own funds?——From our own funds. Just to round off the picture in that field, we are responsible jointly with the Secretary of State for the Colonies for all medical research in colonial territories, and we have a joint committee, of which I am chairman, which has two pockets: one pocket is the M.R.C. budget, the other pocket is the Colonial Development and Welfare Fund. The bigger organisation is paid for by the Secretary of State but is still administered by this joint committee and scientifically directed by it. It is in fact part of a very large remit.

4612. As regards the medically qualified people, Sir Harold, would most of them be Members or Fellows of one of the Colleges, or would they only have taken the earlier degrees?——The situation varies with the subject. If they are in charge of a research unit which actually has the responsibility for the care of patients, then of course they must have the requisite high degrees. In medicine they must have the M.R.C.P. and the M.D., and in surgery they would have the M.S. and M.R.C.S. The M.R.C.Ps. seem to acquire considerable distinction and go up and get their F.R.C.Ps. and numerous lectureships, and so on. If they are in the para-clinical or pre-clinical fields, it is not obligatory to have these higher degrees; you will find in our units concerned with pathology, and so on, that they may have their M.D. without having their M.R.C.P., and in physiology you will find the same. So that it has roughly sorted itself out along the same lines as are required in practice. That happened before the introduction of the National Health Service, because one knew if one were putting a research unit down in a hospital, the Board of

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Governors of the old days would say: "We want evidence that this man is competent to act as a full physician and take charge of the patients"; so that it did tend to sort itself out in that way. In other words, the man whose interests begin to move on to the side of looking after patients will take care that he gets one of these high degrees, so that there is no obstacle to his future promotion because somebody objects to his not having the requisite degrees.

4613. *Professor Jewkes*: Could I ask about the non-medically qualified members of the 600? You have mentioned chemists—I suppose there are physicists?——Physicists are very much in demand at this present time, and physical chemists. At one end you have the chemists, the physical chemists, who have not got medical degrees. Then you come into a kind of borderline where they merge, shall we say biochemistry and physiology, and even extending over into bacteriology. And here medical qualification is rather optional—I do not wish to mention anything in connection with the universities, because that is nothing to do with me, but perhaps if I might use an illustration in this field; if you look at the professors of physiology, you will see one who is medically qualified. When he goes he may be replaced by a non-medically qualified one. The same occurs in anatomy. This is the line where you can get an overlap, an that overlap is a very healthy one provided it does not go to either extreme. If the whole of this borderline field were staffed with non-medically qualified men, it is our feeling that it would lose direction. If it were staffed entirely with medical ones it would fail to be refreshed from the basic field.

4614. Moving from the overlapping area—chemists, physicists—zoologists I suppose are among the 600?——Not employed on our staff. I think we have tended to regard professional zoologists who are employed as falling rather more over to the side of the Agricultural Research Council. When there are zoologists doing work of interest to us, say in a university department, we will give them grants to help them, but we have not employed pure zoologists. We have got some people who have had zoological training who in the course of time have shifted their interests over into the medical field.

4615. Statisticians?——Statisticians certainly. One of our biggest units is under the honorary direction of Professor Bradford Hill—medical statistics, epidemiology—and he of course is not medically qualified.

4616. Psychologists?——Certainly.

4617. You seem to have nearly everything—philosophers?——I do not think so! I wonder if I might give you an example from my own field which shows the extent of this overlap? Recently in the press there has been a great deal of attention devoted to the poliomyelitis vaccine. That is potentially a dangerous vaccine. People have in mind the disaster that occurred in the States in 1955. It has to be tested and looked at exceedingly closely before it goes out. Now we do that testing, and—I may just explain, the M.R.C. does not take on routine, but in a very new subject when routine and research are so near together it may be necessary for us to carry the thing, because we are the only people who can. That is a very onerous responsibility, and it is carried out by our department of biological standards. The present head of that department is medically qualified; he is moving away shortly to a university Chair. He will be succeeded by a man who is his deputy at present, who is not medically qualified. That man will have the whole responsibility for passing poliomyelitis vaccine issued in this country. And I may say that neither of these men come within the merit award category.

4618. *Sir David Hughes Parry*: I think it would be useful if you would indicate to us the manner in which you recruit members of your qualified permanent staff. I believe that is our starting point.——It is very rare for us to advertise; it is nearly all done by invitation. We appoint say a director of one of our units—and a director is of professorial standard. He will go to the scientific societies, and so on, he will see the type of man with the interest he wants, he will approach him and sound him out, and if the man is willing to come then he comes to us. So our recruitment is on a personal and selective basis, as it must be in a thing like research, which depends so much on quality. And so far it has worked exceedingly well. I might just mention a point which is important, and that is

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that, as is mentioned in our memorandum, we believe that the flow of people through our organisation back to the universities, and so on, is very healthy. In fact one of my great difficulties is to keep people, because they always get offered Chairs, particularly in the field of biochemistry. So that when they first come to us we give them quite short-term appointments—three, four, five years—we do not give permanent appointments. We differ from the Scientific Civil Service and all other research councils in that—until people are of proved merit and seniority, until, that is, they are roughly of senior lecturer or professorial status.

4619. There is no particular age at which you recruit?——No, there is no fixed age at all—you are talking about the scientific staff?

4620. The scientifically qualified staff. ——Quite. But circumstances tend to make the age slightly different for the non-medically qualified and the medically qualified. The non-medically qualified man may come to us of course after getting his first degree, his B.Sc. The medically qualified man has a longer course and he is a few years later in coming to us. And if he is going over slightly on to the clinical side we are very anxious that he has some general clinical experience before he comes. So although you may get your B.Sc. men coming at 22, 23 or something like that, the medical ones I would say come three or four years later. But that is just the circumstances of the course.

4621. And that is the time at which it is most important that there should be this free flow?——I would have said it was important at all stages, because the number of people who can support a life of pure research is limited. At the beginning everybody thinks he can. I was talking to some people in I.C.I. the other day and they said that all the people they recruit ask for the research side for a start, but it is quite common for my people to come to me in their middle thirties and say: "You know, I thought I wanted nothing better than to do research twenty-four hours a day, but I do not really think I have got that intensity in me. I want something with a continuing activity that I can take pride in as well. I hate the thought of thinking at the end of twelve months that all my ideas have gone wrong and I have nothing to show for it." You will find them inclining towards the academic side then, and, I would say, quite a number of them. If you look at the Chairs in this country that have been filled by people we have trained, I think we might very well claim that our National Institute is a nursery for professors.

4622. *Chairman*: Do you bring many people in from university Chairs?——Actually from Chairs that is very rare. They are fixed at that stage, just as the very senior people with us tend to be fixed, but in the sub-professorial levels there is a great deal of going backwards and forwards.

4623. When you say the very senior people you are thinking primarily of administrators?——No, of actual research people. There are some people who can have that flow of ideas and originality and can keep it right up to retiring age—it does not always go off at 40.

4624. *Sir David Hughes Parry*: I am trying to narrow the field for the flow. You say that it does not matter very much at the professorial stage. Does it matter at the readership stage? Have you recruited any readers from universities, or senior lecturers?——Yes, people like that have come over to us, certainly; some few remain permanently as heads of divisions, but some have come over rather at the level where they are wanting to follow intensively a piece of work. But there is this interlocking going on the whole time.

4625. Now we come to what you have said in your memorandum—we have been trying to get at it gradually. In your abstract, the last sentence of the first paragraph says: "To this end, the system of remuneration of those engaged in the service of medicine—and particularly in medical research where the medicine of the future is taking shape —should be such as to impose no artificial obstacle to the natural distribution of the available talent between its different branches as need and opportunity develop." I think we recognise the point. You only in fact mention one particular obstacle, the merit award. Reserving that for the time being, are there any others, before we come to that?——That is the major one. If I had not that to worry about I should be confident about medical research in this country in the future,

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and that means the quality of British medicine.

4626. We proceed then I think to the consideration of this merit award or distinction award . . .——I should say "distinction award", I do not know why it came to he called merit award.

4627. You do not like the word "merit"?—I know what the word "distinction" means. I am not quite sure about "merit".

4628. Is not "distinction" also liable to cause a certain amount of unhappiness, as much as "merit"—to those who have not got it?——There are certain recognised criteria of distinction in the country, such as the Fellowship of the Royal Society.

4629. The question I would like to ask is this: in a salaried service, in which you are engaged, are you quite satisfied that a merit award or a distinction award would not cause a good deal of unhappiness and uneasiness among members of the staff, where some would have it and some would not?——I do not think so, because one of the privileges that we have been allowed to keep, and which is approved hy our staff, is that the actual promotions within the basic scales are determined by merit. We have had discussions on this point. We have thus got the freedom to give accelerated promotion when we wish. I have had meetings with my staff from time to time, since I have heen at the M.R.C., and they were quite clear in recognising that in a research organisation everything depends upon quality, therefore you must he able to recognise merit. So within the hasic salary scales we can promote people, accelerate their promotion, and there is the recognition on the part of the staff of the importance of merit in a field like research.

4630. *Mr. Gunlake*: I would like to he quite clear about this. You say promotion is by merit—that means you have no fixed estahlishment?——We have no fixed estahlishment.

4631. If a man shows merit, you can push him up into a higher bracket whether there is a vacancy or not?——Yes, certainly; that is a privilege we have.

4632. *Chairman*: Who settles what the actual salary scales are?——The Treasury approve the salary scales.

4633. Which are related, are they, to the Scientific Civil Service?——No, they are related to the universities. We are told so to devise our salary scales that "employment with you is neither no less nor no more attractive than in the universities."

4634. *Professor Jewkes*: That gives you plenty of scope!——Yes. But, having fixed the scales, it is left to us.

4635. *Chairman*: To decide who fits in where?——Yes, and how many too, which is important.

4636. *Sir David Hughes Parry*: "In the universities" means with reference to the non-clinical or to the clinical teachers in the universities?——It means the corresponding department, clinical and pre-clinical.

4637. *Chairman*: Then are you not ahle if you wish to have some salaries that are the equivalent for instance of a professor's top salary at the university, plus a merit award?——Yes, when they are in the clinical field; and that is one of my great difficulties at this present time. Those members of the M.R.C. who are in control of clinical units do get these awards, and as they are distinguished people they get high awards. May I volunteer something at this stage which will illustrate the situation, and the reason for my Council's concern, I think more graphically than anything else? The Secretary of the Commission wrote to me hefore I came here and asked if I would get out figures to show the remuneration of the non-clinical members of our staff hefore the war in comparison with the clinical members, as compared with now. I have got these figures here and would just like to explain how they are derived. I said I was concerned primarily with merit awards. That is the ultimate incentive for a man—where he can look. I am not concerned with the lower ranks. What is the highest a man can attain to? I have therefore in compiling these figures taken the head men in our individual units and the head men of the major departments of the National Institute for Medical Research. Those are people roughly, most of them, of professorial status—some of the juniors you might call of Reader status. And these are the results. There are not many figures from before the war, but they are sufficient, because our main expansion

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has occurred since then. I have taken ten year intervals: 1937, 1947—because that is the year before the N.H.S. came in—and 1957. I can give you the details afterwards, but if I give you them straight first, it brings out the point. In 1937 the average salary of the heads of our non-clinical departments was £1,310; the average salary of the heads of our clinical departments was £1,320. In 1947 the average salary of the heads of our non-clinical departments was £1,590; the average salary of the heads of our clinical departments was £1,680—that is a 6 per cent. difference, and it is explained by more junior people having been recruited. So up to 1947 there was equality in salary between all people we employed, irrespective of where they were situated and irrespective of the degree they might have taken a long time before. The situation in 1957—I took last year, because this year is not complete yet—is this: in the non-clinical the average salary is £2,720; in the clinical the average remuneration is £4,520—that is due to the merit award. As regards the range in salary, the top salary for a non-clinical man in 1957 was £2,850. The top remuneration being received by a clinical man was £5,350.

4638. *Professor Jewkes*: When you give the figure for the 1957 clinical, it is an average figure for the heads of your units who happen to be in clinical work? ——Who are employed by us—because we have some units attached to universities—professors who are honorary directors—and I have not taken their salaries up because they are purely honorary. These are men who are employed by us.

4639. *Chairman*: I do not like to go into individual cases too much, but earlier on you mentioned a particular instance where you were shortly going to lose someone medically qualified, and as part of this valuable interchange it so happens that he will be succeeded by somebody who is not medically qualified. There will be about that sort of difference, therefore, will there . . . ?——No, because the man who has the responsibility of passing poliomyelitis vaccine, and the vaccine against turberculosis and all the others in this country, is not entitled to achieve a distinction award.

4640. Even when he is medically qualified?——Yes.

4641. *Professor Jewkes*: Up to 1947, if there was this equality between clinical and non-clinical, did it mean that you found difficulty in getting people to act as head of your clinical units?——No.

4642. Would there not be a great difference between their earnings with you and their earnings if they went out as consultants or even as professors? ——In this discussion I have assumed that you do not take into account what a man might make if he went out into private practice. My point was concerned with salaries, the salaries that are paid from Exchequer budgets; they may be out of different pockets but it is the same paymaster. The development of clinical research has come up very rapidly since the war, in this country, and we had not many clinical units in 1947. We had three before the war, that was all.

4643. How many have you now?——We have 40 all told, 40 units and research groups. In fact we have 68 units in being at this present time.

4644. *Chairman*: I just want to be quite certain—you would have had no way open to you under your present constitution and remit from the Lord President, or from the committee of the Privy Council, to have treated the poliomyelitis vaccine unit, for instance, in such a way that the head of that could have got something of the order of the £4,520, instead of £2,850?——Certainly not. It would not be accepted; it would not have a chance of being accepted.

4645. *Sir David Hughes Parry*: I have one other question, but I am keeping that for the time being in case my colleagues want to ask a question about the merit award. I want to ask later on about a memorandum submitted by the staff of the Medical Research Unit, to ask you if you have seen it?——I saw it yesterday.

4646. But we will reserve that for the time being.——The point that I was going to make bears upon this memorandum, the question of when the pressure begins to bear upon these men. I should dislike it to be thought that in medical research workers one is dealing with a peculiarly mercenary branch of medicine. One is not. Of all the branches of medicine that I have met, I think they perhaps have the strongest

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sense of vocation. But in the representations which I have had, the thing which bulked rather larger in their personal representations was what was felt to be the slur on their prestige. There they were, employees of the same source, and yet one branch was felt to merit so much more than another. That was one of the points about it. The other was the question that was put to me rather well by a late professor of physiology, when he said: "Young men are often altruists; fiancés often say they are; mothers of young families are always realists, otherwise the human race would not have survived". The pressure is at the intermediate level, when it is still open for a man to change; and that is where the difficulties are. where the men are becoming key men. And I am anxious about it, not only because of losing them in this country but also of losing them abroad, particularly to North America. These men are pretty distinguished, and although one can never find out with any certainly the range of salaries in the posts in North America, I have made enquiries and I have been told by individual professors: "The only man who knows what my colleagues are getting is the Dean". They do not seem to be published with any certainty, particularly in the older universities. There is no question that these people are being given the most attractive offers, and quite a number of them are people whom this country cannot afford to lose. I am not having to worry about those offers in the clinical field, where the merit awards are payable, whereas I am acutely worried in the non-clinical field, where people are casting envious eyes upon our bacteriologists, our geneticists, our experts—and this is particularly important—our experts on the health aspect of nuclear power. Even those who are working on the diseases which come from radiation exposure, and so on, are not entitled to the merit award.

4647. That is why I was concentrating on the period of recruitment. I have an impression now from what you have said that it may very well be that the age at which you recruit the medically qualified may be a little higher than the age at which you recruit the non-medically qualified, is that so?——Yes, but no more than can be accounted for by the longer length of the course, and the fact that to get your name on the medical register now you have to do a year's clinical work afterwards. It is no more than that, and I would not have said there was any significant difference between the two.

4648. I was trying to keep an eye on the period when the flow has got to be particularly open.——I had not really thought there was any particular difficulty there. It will happen naturally if there is no obstacle. But the other point I would like to make here is in comparing the relative remuneration in different branches of medicine. When a man is qualified there are several openings to him, there are several pathways that he can follow, without doing violence to his own interests in medicine; for instance, the cast of mind that makes a physiologist and makes a consultant physician is a very similar one. It is the same point of view and outlook, and when a man is qualified he can, without doing too much violence to his interests, switch from one which will lead him up to a salary with a merit award tacked on to it at one end, or go on to a line which has not got one at the other end. The point I was anxious to bring out is that this is not an artificial distortion of a man's interests at that stage. Any of them could foresee having quite an interesting life up some other path than the pre-clinical one; that is the point I am making. It is not that the choice before them is the pre-clinical or nothing. It is a genuine choice which one can make in that direction. One can see this shift occurring, and I am particularly perturbed about the operation of this influence, because it is one of the steadily operating factors which will not produce a crisis to jolt people to look at what is happening. We shall just wake up some morning and find that we have denuded these essential branches of medicine, and that will not be remedied overnight. My own feeling is that we are half way there. We have had ten years.

4649. *Chairman*: Sir Harold, in paragraph 8 of your memorandum you say: "Of the 64 Fellows of the Royal Society engaged in such studies and at present in post . . ." How did you arrive at this figure?——This figure can be altered about a little according to judgment. I took my Year Book of the Royal Society and I went through and marked every

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Fellow who was engaged in activities which would qualify him for employment with the M.R.C. These are all the Fellows of the Royal Society who are engaged in medical subjects of any kind; they are not all with us.

4650. You said, and obviously it is true, that to be a Fellow of the Royal Society is a matter of great distinction, and you know that there are some 7,000 consultants entitled to and 34 per cent. of these getting merit awards now. Obviously most of those are not Fellows of the Royal Society, only a very small proportion, is that right?——In the Royal Society at present clinical medicine is very lightly represented. Of people in post, I think there are about eight or nine Fellows of the Royal Society—I would not be certain, I would have to check that—who would be entitled to a distinction award. I was omitting myself, because I was once a professor, and would have been entitled if still in post.

4651. You say there are these 64 Fellows of the Royal Society—of whom 54 would not be eligible for merit awards?——Yes.

4652. Those 54 are necessarily more distinguished than a great many of the 34 per cent.—a great many, I do not say all. Is that a fair assumption?——I would prefer not to answer that question as you put it. These men are distinguished, very distinguished, by the most stringent criteria applied in the advancement of knowledge on the scientific side in this country. They are recognised to be that. I would have said that those men are making essential contributions to the medical field, the type of contribution upon which the development of medicine is built and upon which the future quality of medicine in this country will depend I would prefer to put it that way round.

4653. *Professor Jewkes*: To take up a point you raised a moment ago, Sir Harold: is it true that the pre-clinical side of medicine is more important now in relation to clinical than it was twenty or thirty years ago?——I think it is of increasing importance. If you would put the question "more important than it was twenty or thirty years ago", and allow me to escape from the invidious position of deciding which is the more important . . .

4654. No, please do not escape.——It is certainly more important, and certainly will become more and more important. Take a field like the treatment of cancer with radiotherapy; the quality of physics that has to be applied in order to use those machines on patients is very high, and it is a field of physics in itself, it is medical physics. The man starts as a qualified physicist in the field, but to become a master of it he has got to master the medical side. He is producing a subject of his own, with the net result that after he has been in that field for some time—and this is important—he is not qualified to go back into a physics department; he has ceased to be a pure physicist. So that is one of the important points with these non-medically qualified people. They come into medicine, and medicine changes them into something else, so that they are not able to go back to the basic pure chemistry or pure physics in which they were trained. Therefore medicine has the moral responsibility for them. It is undoubtedly the high quality of support that medicine is progressively getting from people in those fields that is sending it forward at the rate that it is at this present time. I gave some examples: we could never have had penicillin without that co-operation; all these new drugs, these anti-malarials and what have you, that are coming in, it is unthinkable that any practising doctor could produce those. It has to be from this co-operative work with these people. And in the one field with which I personally have to concern myself at this present time to a very great extent, that is the field of nuclear energy and all that it means to the human race from the point of view of the health of this generation, the health of workers in the plants, and the health of future generations, in that field you cannot move without the highest grade assistance—physicists, radiobiologists, and people of that kind, who are called medical physicists or health physicists, because they moved out of the physical field. I do not know if I have answered your question?

Professor Jewkes: Yes, thank you.

4655. *Chairman*: Going on from the point about changing around. In these two different spheres you have one very high ceiling and one very much lower. Does that affect the salaries and the scale that you can pay to the people within

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those units further down?——No. The ceiling that we go up to—if I take the last year, 1957, they were both equal, £2,850; but we could pay £3,100 as a ceiling for the clinical. That is the reason why in 1957 there is a slight difference between the basic pay, because the ceilings were slightly different. Lower down it does not matter.

4656. It does not matter if you have somebody getting £5,350, and the man immediately under him will be very much further below him than the man under the one who is getting £2,850?——That depends, Sir. I am sorry, I slightly mistook your question. There are really two parts in this. If one takes the basic salaries, they come up to ceilings that are a little different. Beneath those ceilings we just give the same basic salaries to either side, whether they have got medical degrees or not. It depends on their merit. When you get above that ceiling you get into the range of merit awards. Any man who has an honorary consultant post with the National Health Service is entitled to a merit award, and there may be more than one in a big clinical unit. They are the senior people, of course. So it might follow that the head of the unit has a merit award, and the one underneath him has one also. That is the position.

4657. Might it have followed that the head of the unit was not eligible for an award and the one underneath him was?——Not as things stand at this present time. I can think of one of our units in which that might conceivably arise—the director is not medical, and the man on the clinical side of the unit is clinical. I had not met that particular difficulty, but I could see it could arise; he might get a merit award whereas the director could not.*

4658. Yes. This Treasury formula which says that the Medical Research Council salaries should be "neither no less nor no more attractive than in the universities" is an important one. Is that common to other branches of the research activities, do you know?——No, it is unique to the Medical Research Council.

* Sir Harold Himsworth has since informed the Royal Commission that his answer to this requires correction. The answer should be "Yes, that situation has in fact just arisen and the one underneath has an award."

4659. When was it produced?——The actual formula I think was written round about 1948, but it had always been understood. You see, we are the oldest of the organisations, and we were established in that way.

4660. The formula dealt with what was already happening?——It was formulating what was practised.

4661. So that the announcement of the formula really was made in consultation with the Council? There was some consultation with the Medical Research Council, but at that time the question of merit awards had not obtruded itself very much?——No, since 1913 when we had started off, this had been the understanding.

4662. And generally speaking do you regard that as a reasonably flexible formula and approach?——I do, yes.

4663. Apart from this particular difficulty?——Apart from this particular difficulty.

4664. *Mr. Gunlake*: May I ask a question on paragraph 14 of your memorandum, Sir Harold? That is a paragraph which refers to the strain of responsibility, which is simultaneously important and difficult from the point of view of this Commission. It has been argued before us by those who carry the clinical care of patients that the strain which they bear of responsibility for human life, health and happiness, is something which is different in degree, and perhaps different in quality, from the responsibilities borne by members of other professions. Last week we had before us the medical officers of health, who stressed the responsibility which they carry for social or community medicine and preventive medicine. In your memorandum and again this morning you have referred to the quite clearly grave responsibilities carried by the head of the vaccines departments. And yet we have a sentence in this paragraph 14 which pulled me up short when I came to it, where you say: "The ability of a man to support any particular responsibility depends to a large extent on his training". I wonder if you could help us by enlarging a little on that? How far would you press that view?——May I say, before answering your question, that I was a physician, I am a physician, that I have been a consultant physician, and I was a Professor of Medicine at University College

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Hospital and consultant physician on the staff there, and I carried this responsibility until I went to my present post, so I am talking now of my personal knowledge. And by responsibility I take it that people are meaning the anxiety inseparable from certain duties that they have to discharge. I do not wish to be sententious on this point, but the particular sentence you picked out comes from Xenophon. This argument occurred in one of the Socratic dialogues, where a young man came to Socrates saying that he had great ambitions to be a governor or a general, but he had not the self-confidence to do it, and then follows the famous argument of the helmsman on the ship, when the general is shaking with fright but the helmsman is standing at the helm—why? Because of his training. I am sorry to be sententious on that, but that argument has been thrashed out two thousand years ago.

4665. *Professor Jewkes*: There is at least one philosopher on the Medical Research Council, Sir Harold! (*Laughter.*)——I think this is absolutely true: in the clinical field, you start as a medical student; after a few months you are allowed to put a needle into a vein, and you are covered with perspiration the first time you do it. Then this becomes routine, and you go a bit further and a bit further, and you start delivering babies, and steadily step by step this builds up and by the time you become a physician or a surgeon it is second nature. I am not saying one does not walk away and worry about it, but there are worries on the other side too. Since I have come to my present job I know that I am bothered when a new drug is being tried for the first time on a human being, even though I am not actually giving it. I have taken the responsibility, I have said that all the tests on animals show that this should be all right, but I must admit that I have heaved rather a sigh of relief when the first stage has been got over. I mentioned this particular instance of the man in charge of the poliomyelitis vaccine; there he has the knowledge that a disaster did occur in the States and people were paralysed and people were killed, and he has to take the responsibility of passing that vaccine for thousands of people. I think myself, on this question of responsibility, that the ability of a man to support any particular responsibility does depend to a large extent on the training, and that there are responsibilities outside the clinical field which are as onerous as those within. And on the border line over which the merit awards spill, the so-called paraclinical field, there is certainly nothing to choose between those who are eligible and those who are not.

4666. *Mr. Gunlake*: If we were to add after the word "training" the words "experience, personality, and psychological and physiological state of health", do you think we would have improved on Xenophon?——Am I to draw the inference from your question that you think there is a kind of process of natural selection at work?

4667. I was questioning whether training alone answers this problem.——I think myself that it is a major factor. You can put in experience—training and experience—but in the medical training up to consultant, experiences are very deliberately graded, and of set purpose.

4668. *Professor Jewkes*: Sir Harold this is a more general question: the group of experts who are eligible for merit awards have a ring placed round them by the use of the word "clinical", and although as you have shown it is not as simple and straightforward as that, it sounds simple and straightforward. How would you define the rather different circle that you would like to create, so that people would accept this as fair and just?——You are asking me to go beyond my Council's brief now on this particular point. Naturally when they were considering this matter they also remembered the other half of the question about distinction awards which the Royal Commission put down on paper—alternative ways of dealing with them. But they were anxious to keep this to the principle, because there might be many and different ideas about ways and means. It would, I think everybody recognises, require redefinition. But anything I said on that would be purely personal.

4669. Perhaps I put the question badly, Mr. Chairman. What I was really trying to get at was this: you talk in terms of another 500 non-medically qualified experts whom you suggest should be eligible for merit awards?—— I am being very proper and confining myself to the 100 in the employ of the M.R.C.

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4670. All right, let us take the 100. How do you define them so that they can he distinguished from all the other scientists who exist in medical research and in the universities?——I would not like to put this forward as a definition I have produced, if one were putting up a scheme or something like that, hut the thing which distinguishes those 100 people is that they are all engaged in research which is directed to medical ends.

4671. *Chairman*: Yes, hut would you differentiate simply in the field of research? Would you differentiate between those who are very eminent in research directed to medical ends and those equally eminent in research directed to some other scientific end? ——Do you mean within the medical field?

4672. No.——I think, Sir, that that is a question which takes me outside my remit.

4673. Yes, but all the same, Sir Harold, these people on the whole come out of the same sort of stratum of intelligence in the community; they have the same ideas about advancing knowledge and doing something really useful for posterity, and it is not only in the medical sphere. There may be many other spheres of activity in which research workers find themselves to some extent Government-paid, eventually by the Treasury, would you not think so? ——I am afraid I have not quite got this—you mean people employed by the Department of Scientific and Industrial Research or the Agricultural Research Council?

Chairman: Yes.

4674. *Sir David Hughes Parry*: And the universities.——I was confining myself strictly to this field, because I was not empowered to go heyond it.

4675. *Chairman*: Yes, but one of the things that seems to cause some difficulty here is that there has heen a separate category of people created since 1947, who are put in quite a different box?—— Yes.

4676. Do you make it any easier for the community as a whole if you enlarge the category but still have a separate category for which only a small part of the community as a whole are eligible? ——There is no question at all that there is a very embarrassing prohlem here. All the scientific members of my Council are university professors, and they are therefore very well aware of this particular point. At present the line is drawn in the most arhitrary way, which is quite difficult I think to defend. The question that you are asking is: would it cause more trouble if it were drawn at the bottom of the medical faculty instead of down the middle of it, in a wavy line?

4677. Yes. The question is whether when one anomaly is got rid of it produces a lot more anomalies, or not.—— That is a question which concerns other people; it is outside my remit. But what I was sticking strictly to here was a division drawn in the middle of medicine which was going to affect the quality of the whole structure of medicine in this country.

4678. I fully take the point, hut you feel, I think, Sir Harold, that this difficulty has arisen partly at least because there was at the time of the Spens Report an artificial segregation of one part of the profession, that is right, is it?—— That is what I think personally.

4679. One part was looked at in blinkers, and if we look at an enlarged view of one part of the community in blinkers it may not cure all the difficulties.——If it were enlarged to cover those engaged in medicine we would not he concerned about the future of medicine in the country.

4680. *Sir David Hughes Parry*: If the scope was shifted so as to cover all your men it would remove your embarrassment but it would create embarrassments elsewhere.——And it would also be salvation for some! Of course, their prohlems in their departments are pretty much the same as ours.

4681. *Professor Jewkes*: Could I take up an intermediate position as we are so anxious you should help us here, Sir Harold? Suppose there was a case where you were not employing but you were financing some chemist—a man, say, in a university. If you thought the work he was doing was a long shot hut that it might have some importance, would you feel that sort of man ought to come into the circle and he eligible for a merit award?——No. We finance

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in two ways, by employing the staff and by giving grants to people who are in the employ of others and universities. We give a large amount of money in that way and I would say for the kind of long shots where something might come off. We finance it on that basis but we do not regard those people as employed by us, or responsible. Now, if something new came out so that a new subject was emerging which was nearly medical, or could be made medical, such as, shall we say, biophysics—that was started by physicists who began to get near to the biologists —and there was no place for it at that time anywhere else, if we took that and developed it we would take those people into our own employ because the future would be too insecure for them otherwise. Here is a risk subject; somebody started it, but if it has to be developed we have to give them the security so that they can develop it. Then they would come on to our staff, but we should have to be satisfied that it was of medical relevance before we could justify the spending of public money.

4682. *Chairman*: Do you find a big difficulty from time to time with something that is just on the borderline. Do you have some hesitation in deciding whether it is in, or not?——Certainly, and there are frequent meetings between the Secretaries of the three research councils, the Nature Conservancy, or the Chairman of the U.G.C. and the Secretary of the Royal Society. We meet and compare notes, particularly the three Secretaries and the Chairman of the U.G.C. When it is a borderline case there is often a discussion as to which side it should be on—I say "often" although this sort of thing does not arise as frequently as you would think.

4683. I have not formed any idea as to its frequency but I suppose there are always a few marginal cases at any time, are there not?——There are a few marginal cases but, shall I say, less than one would suspect—that is what I should have said.

4684. *Sir David Hughes Parry*: I was going to ask whether you have seen this memorandum from the medically-qualified staff of the National Institute of Research?——I just saw it yesterday. In fact, the Secretary mentioned it to me over the telephone and sent me a copy.

4685. This may be the only opportunity we may have and we ought to give you the opportunity if you want to do so to make any comment on any matter in it.——I knew that the members of the National Institute, which is one of our Institutes, had applied to send in written evidence and, of course, they have a perfect right to do so on the matter. I looked this through and they have tackled the thing in rather a different way but the substance of it is very similar to what we say.

4686. So you do not desire to say anything else then?——No, I do not desire to say anything on the matter at all. Perhaps I might just make one point that they mention and which we have not made in our memorandum, and that is the question which the senior people notice, the question of pension. A person who is entitled to a merit award, a person in our employ or employed by a university, who is entitled to a merit award, that merit award is pensionable under the F.S.S.U. system so that it makes quite a difference to their retiring pension and we omitted to mention that.

4687. A difference in the pension as well as in the salary you mean?——Yes, combined together.

4688. *Chairman*: We shall probably be printing their evidence at the same time as yours, I suspect. Broadly, you do think the general impression from the figures they quote is in accordance with yours?——Yes, the general impression from the figures is correct. Of course, there is always difficulty in calculating probabilities.

4689. *Professor Jewkes*: There is one minor point which Sir Harold can help us on. When giving figures in his own paper in paragraph 13 he talks about 100 people in the para-clinical and pre-clinical departments of the Medical Research Council and in the footnote he refers to a further 300—a total of 400, some of whom would not have medical qualifications.——Certainly, yes. I noticed that discrepancy when I looked through this and I do not know where their figures were obtained from.

4690. They are quoting 400 which would be those people only with medical qualifications.——I do not quite understand how this has arisen. I am talking

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purely about non-clinical. I do not know whether it will mean all the clinical ones are included in that. I do not know how that arises. This figure of 100 I can answer for and I do not think you will find the other one incorrect.

Chairman: Thank you very much, Sir Harold. You have given us a most interesting meeting, and most useful information, and you have concentrated attention very much on part of a problem of which we are very conscious. We are very grateful to you for coming.

(*The witness withdrew.*)

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COMMITTEE OF VICE-CHANCELLORS AND PRINCIPALS OF THE UNIVERSITIES OF THE UNITED KINGDOM

General evidence submitted to the Royal Commission on Doctors' and Dentists' Remuneration

Introductory

Many of the heads under which information is sought by the Commission are not directly applicable to members of the academic staffs of Universities. There are, for example, no established courses or schemes of training for those seeking to become university teachers and thus no useful information can be provided under the several heads which relate to "the quality and quantity of recruits", "wastage during training", "the duration of training" and "earnings whilst training". The Committee has, however, provided information under such of the remaining heads as it judges to be relevant and this is set out below, numbered according to the list of points supplied by the Commission.

2. *The quality and quantity of newly qualified members of the profession*

The number of persons starting on their careers as members of the academic staffs of Universities necessarily varies from time to time according to the actual requirements and there are inevitable difficulties in these circumstances about giving reliable quantitative information. The tendencies since the last war have been generally for increased numbers to be required but there has been substantial variation from year to year. For example, in the period immediately following the last war the expansion of the academic staffs of Universities was considerable; during the last few years the numbers entering the profession for the first time have shown a reduction; but in the 1960s there is every expectation that the numbers required will again increase. In relation to the total number of those graduating, however, the proportion required by Universities to replenish or augment their academic staffs is not significant, and in most fields of academic activity the Universities have been able to maintain, so far as their finances have allowed, a staff which was adequate numerically. The difficulties of Universities as regards the size of their academic staffs are more related to their financial resources than to the availability of candidates.

As regards quality, it is a well established principle that appointments to the academic staffs of Universities should be reserved for those with high academic qualifications and the Universities expect to continue, as they have done in the past, to recruit from amongst those who achieve the highest academic honours. Departures from this criterion are occasional and not significant in principle and are due to special factors relating to particular posts. In many fields of academic work the Universities are able to select with a fair amount of freedom from this extremely restricted class of graduates; as regards other fields of interest there is a greater competition for the services of those with the highest academic qualifications.

6. *The qualifications necessary for entry into the profession*

The minimum qualification for entry into the profession is a high honours degree of a University of standing and to this in the great majority of cases must be added successful postgraduate work for which a higher degree is frequently conferred. In addition to formal qualifications, appropriate experience is almost always essential, but within the university system there is a fair provision of opportunity for gaining such experience in the form of demonstratorships, junior fellowships, research assistantships, research associateships, etc. Other qualifications and experience are necessary in some faculties; for example in technology and in some subjects closely related to professions, professional experience and sometimes professional qualifications are necessary. Broadly speaking the practice of Universities throughout the Commonwealth is common and the qualifications relevant to membership of academic staffs of Universities in the United Kingdom are recognised throughout the world.

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7. *The earnings, prospects and problems of a newly qualified member of the profession*

The experience of a man or woman who finds a place on the academic staff of a University is not analogous to that of a man or woman obtaining a professional qualification and beginning to practise the profession to which that qualification relates. The evolution of the undergraduate into membership of the academic staff of a University is a process involving advanced study and research coupled with the gradual acquisition of university experience. The scales of salaries current in Universities provide for employment in four main grades, namely, the professoriate; Grade I, which includes assistant professorships, readerships and senior lecturerships; Grade II, which is the great staple of the profession, comprising the lecturers; and Grade III, which includes assistant lecturerships, tutorships, etc. There are many who establish themselves on the academic staffs of Universities through the assistant lecturer grade, while others who seek academic careers at a later age on the basis of more extended experience enter the lecturer grade. The remuneration of the various levels of university employment in the United Kingdom conforms in general to a common pattern and full information is given in reply to a later question. When entry to an academic career is through employment in Grade III the salaries appropriate to the grade apply and they are related to a minimum age of about 25 or 26. The period of time spent in this grade varies but is of the order of three or four years. While an appointment in Grade III offers a high probability of a subsequent appointment in Grade II there is no guarantee that such an appointment will follow and commonly there is a maximum period for employment in Grade III. Thus a man or women obtaining an appointment in Grade III, if a lecturership is not obtained within a period of, say, 5 years, must look outside the Universities for a career. The general circumstances of those looking for employment on the academic staffs of Universities are financially less rewarding than many kinds of employment which at that stage could be obtained on the same qualifications. To an appreciable extent therefore the Universities rely upon a sense of vocation and a liking for university life to attract men and women of higher qualifications in sufficient numbers.

9. *The nature and range of expenses*

The principal expenses incurred by members of academic staffs in the performance of their duties are those in respect of books and subscriptions to the journals of the various learned societies and, depending upon their particular subject, possibly also in respect of scientific instruments and items of personal equipment. It is not possible to give any indication of the range of such expenses. The extent to which they are "allowable" for the purposes of income tax varies from one district to another according to the arrangements made locally with the income tax authorities; there is no agreed schedule of expenses which are "allowable" to university teachers.

10. *Existing arrangements for the determination of professional remuneration*

The rates and scales of salary on the basis of which Parliament is asked to make funds available to the Universities through the University Grants Committee are determined by the Chancellor of the Exchequer. Having regard to these limits, each University determines individually the precise rates and scales to be applied to the members of its academic staff. Before reaching conclusions in this respect, however, it is customary for the heads of the individual Universities to consult together informally through the medium of the Committee of Vice-Chancellors and Principals. Representations as to changes in the basic salary framework for academic staffs may be made to the University Grants Committee at any time by the Association of University Teachers or by the Committee of Vice-Chancellors and Principals, both of which have a formal right of approach to the University Grants Committee on this subject. It is the duty of the University Grants Committee, after examining any such representations, to give a considered reply, if necessary after making a submission to the Chancellor of the Exchequer. There are no arrangements for the automatic adjustment of salaries to take account of rises in the cost of living.

13. *The salaries now in force*

On 12th March, 1957, the Chancellor of the Exchequer announced in the House of Commons that he proposed to ask Parliament to provide the additional funds

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required to enable the Universities to bring into effect new rates and scales of salaries for full-time staff from 1st August, 1957. The details are given below.

Non-Medical Posts*

Professors: The grants will be related to basic salaries of £2,300 a year in Universities and University Colleges. Provision will continue to be made for supplementation and this will allow for a range of salaries up to £3,000 a year.

Readers and Senior Lecturers: A range of salaries with varying maxima up to £2,150 a year, or in special circumstances to £2,250 a year.

Lecturers: Scales rising generally from £900 × £50 to £1,350 × £75 to £1,650 a year.

Assistant Lecturers: Salaries rising from £700 × £50 to £850 a year.

Pre-Clinical Posts*

Professors: Salaries ranging from £2,300 to £3,000 a year.

Readers: Salaries within the range of maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £900 × £100 to maxima ranging from £1,650 to £2,250 a year.

Clinical Posts

Professors: Salaries ranging from £2,500 to £3,000† a year.

Readers: Salaries within the range of maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £900 × £100 to maxima ranging from £1,750 to £2,550 a year (or in the case of lecturers holding posts of special responsibility such as the headship of an independent department, £2,900 a year).

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14. *Alterations of remuneration since the war*

Apart from the revision with effect from 1st August, 1957, academic salaries have been revised twice since the war. The first revision took effect from October, 1949 (April, 1949 in the case of clinical staffs) and the second from October, 1954. Details of the rates and scales in respect of each of these revisions are given below.

1949 REVISION

Non-Medical Posts

Professors: The grants will be related to basic salaries of £1,600 a year in Universities and University Colleges (in London £1,650), with increased provision for supplementation allowing for a wider range of salaries than hitherto.

Readers and Senior Lecturers: A range of salaries with varying maxima up to £1,600 a year.

Lecturers: Scales rising generally from £500 to £1,100 a year.

Assistant Lecturers: Salaries ranging from £400 to £500.

Pre-Clinical Posts

Professors: Salaries ranging from £2,000 to £2,500 a year.

Readers: Salaries within the range of the maxima indicated overleaf for Lecturers.

* Additional allowances of £100 for Professors, £80 for Readers and Senior Lecturers and £60 for others will be paid to pre-clinical and non-medical staffs of London University.

† May be increased to £3,100 in certain cases. [This figure has since been changed to £3,250 in consequence of the 5 per cent. interim salary increase awarded to consultants in the National Health Service. The " certain cases " referred to are clinical professors who do not hold either an A or a B distinction award.]

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Lecturers: Scales of salary rising from £600 a year to maxima ranging from £1,200 to £1,800 a year.

Clinical Posts

Professors: Salaries ranging from £2,250 to £2,750 a year.

Readers: Salaries within the range of the maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £600 a year to maxima ranging from £1,500 to £2,000 a year (or in the case of lecturers holding posts of special responsibility such as the headship of independent departments, £2,500 a year).

1954 REVISION

Non-Medical Posts*

Professors: The grants will be related to basic salaries of £1,900 a year in Universities and University Colleges. Provision will continue to be made as at present for supplementation and this will allow for a range of salaries up to £2,850 a year.

Readers and Senior Lecturers: A range of salaries with varying maxima up to £1,850 a year.

Lecturers: Scales rising generally from £650 to £1,350 a year.

Assistant Lecturers: Salaries ranging from £550 to £650 a year.

Pre-Clinical Posts

Professors: Salaries ranging from £2,250 to £2,850 a year.

Readers: Salaries within the range of maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £700 a year to maxima ranging from £1,450 to £2,050 a year.

Clinical Posts

Professors: Salaries ranging from £2,500 to £2,850† a year.

Readers: Salaries within the range of maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £700 a year to maxima ranging from £1,750 to £2,400 a year (or in the case of lecturers holding posts of special responsibility such as the headship of an independent department, £2,750 a year).

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16. *The extent to which members are required to work away from home or to move house in pursuit of work*

Members of academic staff usually choose and are sometimes required to reside in the immediate vicinity of their University and will not normally be required to work away from home. Among the Universities generally, however, considerable importance is attached to the existence of a high degree of mobility of members of academic staffs between institutions, and promotion is very often obtained by securing a more senior post at another University. This factor is of importance at all stages of an academic career and no distinction can be drawn between the early and the middle period.

17. *Any other special factors of attraction, expense or hardship, which distinguish the profession from some others*

Reference has already been made above to the need for Universities to rely on a sense of vocation and the attractiveness to some men and women of higher

* An additional allowance of £50, within a maximum of £2,850, will continue to be paid to non-medical staffs of London University.

† May be increased to £3,100 in certain cases.

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intellectual ability of university life and conditions. The relative appeal of life and work in the Universities has, however, appreciably changed in the last few decades with the increasing attractiveness of employment in the government scientific service and of many other kinds of employment, both technical and general, in industry and commerce.

18. *The practicability and prevalence of members transferring to other work*

Many members of academic staffs, particularly those in the fields of engineering and the other applied sciences, can readily transfer to work in their own field outside the Universities. It is not possible to give a measure of the prevalence of such transfers but the Universities are constantly subject to pressure in this respect as a result of the needs of special government services, of industry and of commerce and also owing to the existence of strong competition from overseas, particularly from the U.S.A.

19. *Arrangements for retiral and superannuation*

The effective age of retirement in the Universities varies from 65 to 70. The normal method of provision for retirement benefits for members of staff is through the Federated Superannuation System for Universities, of which all the United Kingdom Universities are constituent members. The conditions of the F.S.S.U. require annual contributions equal to 15 per cent. of a member of staff's salary (10 per cent. being paid by the University and 5 per cent. by the member) and these contributions are used to pay the premium on an endowment or deferred annuity policy on the life of the member of staff concerned. Further policies are taken out in respect of any subsequent increments in salary. Upon retirement a member of staff receives, normally in the form of an annuity, the proceeds of the various policies held by his University on his behalf.

20. *Any other relevant information*

Reference has already been made to the fact that there are members of most professions to be found on the staffs of Universities. This is the case so far as doctors and dentists are concerned. In 1949 the presence of medically qualified members of academic staffs was a complicating factor in the settlement of academic salaries then reached and it resulted in the establishment of differentiation as regards remuneration between those with medical qualifications and those who were not so qualified. The further differentiation was introduced between those who being medically qualified were engaged in clinical work and those whose work though medical was not in the full sense clinical. In addition to these differentiations which will be seen to be inherent in the statements of salaries for 1949, 1954 and 1957 it is the case that members of the staffs of Universities who being medically qualified are also engaged in clinical work, are eligible together with their professional colleagues employed in the health service for distinction awards.

The terms of the statement of academic salaries reached in 1949 and 1954 and again in 1957, so far as they related to members of academic staffs with medical qualifications, were fixed having regard to the remuneration available to their professional colleagues employed in the health service. It will be seen for example that the range of clinical salaries provided for in the salaries settlement reached for 1957 makes possible the employment of medically and dentally qualified members of academic staffs on financial terms which are comparable with those which would be available to them if they were employed in the health service.

It is clear that the comparability of remuneration for medically and dentally qualified members of staffs in Universities with those which would be available to them if they were employed in the health service will no longer obtain if there is some general improvement in the remuneration of doctors and dentists employed in the health service. Further, any arrangements as regards distinction awards could not be without implications so far as the remuneration of academic staffs of Universities was concerned.

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Examination of Witnesses

SIR PHILIP MORRIS, *Chairman*
DR. R. S. AITKEN
MR. J. S. FULTON
DR. T. M. KNOX
DR. D. W. LOGAN
SIR FOLLIOTT SANDFORD

on behalf of the Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom

Called and Examined

4691. *Chairman*: Sir Philip, you are acting as the principal spokesman, are you, for the Vice-Chancellors?——*Sir Philip Morris*: I am acting as the leader of this group, yes.

4692. I imagine they will all say what they want to say in reply to any questions, will they?——I hope you will allow anyone else to intervene if they wish to do so.

4693. That is what usually happens, and you in your turn will be asked questions, primarily by Sir David, whom we reckon knows a bit about Universities, but also hy any other member of the Commission.

When we met you once before we had a private talk, about a year ago, hut on this occasion, as you know, it is in public and, therefore, anything you say ought to he something that can be written down and also something that can be heard by people either listening or taking notes behind you—the Press. ——I take it, it may he used in evidence against me, even if it is, as evidence, no use to you !

4694. I propose to start straight off by turning you over to Sir David but could you just tell me first for the record what is the status and composition, as it were, of the Committee?——It is set out fully in great particularity in Whitaker and also in the Universities' Yearbook, that it is in essence an advisory committee and it exists with the authority of the Universities. It is composed of the executive heads of the Universities and University Colleges together with the addition of the Registrar of Oxford, the Registrary of Cambridge and the Principal of the University of London.

4695. In its relationship with the University Grants Committee, for instance, is there a division of functions that is easily described?——Its relationship with the University Grants Committee depends entirely upon custom and customarily the University Grants Committee regards the Vice-Chancellors' Committee as a convenient channel of consultation on matters which are of general importance to Universities. All such consultations are carried out on both sides, it being present in their minds that the Universities are each of them independent and sovereign bodies.

4696. And the Vice-Chancellors and Principals are, among other things, concerned with remuneration of all their staff and they co-ordinate their activities within the different Universities to some extent, do they?——The actual position of Vice-Chancellors in their own Universities is determined by charters and statutes of the several Universities but, I suppose, each of them has, according to the constitution of his University, some substantial part in the determination of most matters which are determined by the University as a whole. On the position of the Vice-Chancellors' Committee in relation to the University Grants Committee on salaries in general as opposed to the particular remuneration of individual people I take it there may be questions about that later and there is no need for me to explain that in advance.

Chairman: Yes.

4697. *Sir David Hughes Parry*: I think we had better start with the Willink Report, if we may. I take it you have studied it and the Vice-Chancellors' Committee have probably some views to

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express on the matter. Would you like to make any comments on the Willink Report as far as we are concerned?—— I do not think we have anything very important to contribute on that. You are right, of course, in thinking that the Willink Report has been considered, I expect, in all Universities that have medical schools, and it has also been considered to some extent by the Vice-Chancellors' Committee. Except for taking note of the general warning of the Willink Report that there was no need in the opinion of that Committee at present to be anxious about the adequacy of the profession so far as numbers were concerned we have taken no further action upon it at present.

4698. We are naturally interested not only in the numbers that would be taken in at the Universities but also in their quality. Have you any observations to make on the quality of those who are being recruited as students into the medical faculties? Can you make any comparison between the quality, say, to-day and perhaps immediately after the war and in pre-war days?——In the first case, as regards numbers, I think it is probably true to say that it is generally accepted that there is no need at present for proportionate expansion in the size of medical schools as the Universities themselves grow, and as far as I am aware there is no disposition on the part of any medical school to expand itself in size.

On the question of quality, I suppose that the Commission has already become aware that that is entirely a matter of opinion and not a matter of fact, and on this matter, of course, opinions differ very considerably. I think that some of my colleagues, certainly the one colleague who is himself a doctor, probably should say something about this. On the other hand, there are perhaps one or two simple things which can relatively easily be said. For example, as compared with before the war the recruitment in medical schools has been influenced in a number of directions by the general development of an awards policy. That has had a number of effects, two of which are certainly of importance. The first is that medical training has become more accessible to those who before the war would have regarded the medical profession as not being open to them on grounds of finance. On the other hand, it has had the effect, particularly in a rapidly inflationary situation, where those who were in the kind of income brackets who would have regarded medical training as within their means found that the length and the cost of the course in relation to the available net income was increasingly oppressive.

The second point which I think could be made, sticking, which I am doing, to what is fairly common ground, is that there has been as compared with before the war a very considerable decline in the number of medical students who could be regarded as dedicated to the life of being a medical student. The proportion who would be expected to qualify in the minimum time, or with only a very reasonable over-run over the time owing to accident has increased. Whether the quality of the ablest medical students—whether they be considered either as scientists or as doctors, if there is a distinction between the two—has improved or deteriorated gets us on to ground where I think there would be probably no complete agreement. Whether the fairly large number who occupy the average or better than average positions has increased, I think everybody would agree that it has, and I think everybody would agree that the tail has sensibly diminished. As regards the comparison between students offering themselves for medical courses and students offering themselves for other courses which in some respects could be regarded as similar, again there would be a good deal of difference of view.

Might I suggest that perhaps at least Dr. Aitken, who I think you know is medically qualified and is the Vice-Chancellor of Birmingham University, should have an opportunity of saying anything he wishes to say. And on this which is so evidently and obviously a matter of opinion I think that any other of my colleagues should have the opportunity of disagreeing with anything that I have said if they have good cause for doing so.

4699. We have had many opinions expressed on this matter and I think we ought to give you an opportunity of expressing yours as we realise it is a matter of opinion.——*Dr. Aitken:* I can add very little. I agree with the

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impression that Sir Philip has quoted. I have heard the same impression conveyed by a number of people and it seemed to me as likely as any to be the right one, namely, that the average intellectual quality has improved since the war and the proportion of weaker people has been less. There has been no impression conveyed to me that the proportion of very good people at the top has increased and there is a suspicion that it may perhaps be a little less.

4700. *Chairman*: Dr. Knox, I thought you were shaking your head at one remark a moment ago.—*Sir David Hughes Parry*: I thought that too.—— *Dr. Knox*: I think that my medical colleagues would want to draw a distinction here between intellectual quality and what one might call moral quality, meaning by "moral" the whole of a man's personality, character and so forth. And it might be said that while you get a number of applicants who could produce more and better passes in certain examinations you could not say that the moral qualities which you often want to find in those who are going to be doctors were present in all of those who became accepted for a medical curriculum. In Scotland the experience is that the number of applicants to the faculty of medicine has declined considerably in recent years.

4701. *Chairman*: Is it still larger than before the war?——In Glasgow and Edinburgh I could not say, numerically, whether the number of applications is higher than before the war but I think it possibly is. But the proportion of the applicants that even the large schools in Glasgow and Edinburgh have to reject is much lower now than it was a few years ago. In our case, in St. Andrews, we were rejecting many more two or three years ago than we are now, and I believe that in Aberdeen last October they did not even quite fill the number of places that they had available. Overall, during the last few years, there has been a decline certainly in the number of applicants for medicine. You find that of those you accept a high proportion are, in the first place, the sons or daughters of doctors and, secondly, the sons and daughters of other professional men; and these come, according to my medical colleagues, almost always with a sort of sense of vocation themselves in that they really wish to do medicine either because it is a family tradition or because it is the profession that they want to devote their lives to. But there is a remainder amongst the applicants who are intellectually qualified but you cannot always be certain, so my colleagues tell me, that they really have the same motives and the same personal and moral qualities that you could almost rely on, let us say, 20 years ago. That may be a point which is not altogether without importance. For a doctor you cannot just judge on intellectual quality alone and in actual fact, of course, a great many of those accepted into medical schools in Scotland have not been intellectually outstanding but they have had qualities of character and perseverance, and so forth, which have carried them through the medical curriculum. It may be that in some instances you have people of higher intellectual quality but perhaps not of exactly the same moral quality as might be desired. That was simply the experience of my medical colleagues and I wanted to try to distinguish between intellectual and moral qualities.

4702. You attribute that to the general change in the educational opportunities, do you?——Yes.—*Sir Philip Morris*: You will see that there are varying experiences and varying opinions.

4703. Yes, I see that.——I think that is the important point, that the experience is different.—*Mr. Fulton*: I think perhaps I ought to say I have consulted in particular one of my medical colleagues who taught in Edinburgh and is now in the University of Wales. While he would exactly re-echo the opinions expressed by Sir Philip and Dr. Aitken he did want me to add, if there was an opportunity, that he thought that the burden being placed upon these young people, whose average quality in general (not drawing the distinction made by the Principal of St. Andrews) he thinks their general average quality has not in his experience declined—he does think the burden placed on them, both intellectually and as people, has not been reduced but in fact stepped up, and that they are standing up to it extremely well.

Chairman: Thank you.

4704. *Chairman*: You may know, Sir Philip, that we are having a talk later this evening with some of the Deans of

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the medical schools in which this sort of subject will certainly be discussed.——*Sir Philip Morris*: If I may be less serious for a moment—there is no harm I think in that, is there?

4705. None.——I am always reminded in trying to judge what a medical student is going to be like as a doctor by what the lady who saw medical students misbehaving in the street said to her friend, which is: "What very nasty people medical students are. How very different from the nice young doctors one meets"! One of the rewarding things in my life is to see medical students gradually emerge into full qualification and become doctors; and it would not be uncharitable to say that in many cases they have become unrecognisable in the process!

Chairman: Caterpillars are not always like butterflies, are they!

4706. *Sir David Hughes Parry*: I wonder if we could move to the second paragraph in your memorandum, the quality and quantity of newly qualified members of the academic profession generally; you indicate that in the 1960s there is every expectation that the numbers required will again increase. You anticipate that there will be keen competition still for entry on the staffs of the Universities. That is what you think, is it?—— Paragraph 2 of the evidence, I think I ought to make quite clear, relates to the academic staffs of Universities generally and is not related specifically to the medical staff.

4707. It does apply to the medical staff as well as to the general staff of the University, does it?——I think that ought to be explained. The expectation, as I think members of the Commission know, is that Universities will expand very substantially in numbers between 1960 and 1970 but the expectation also is that the expansion will be unequal in various directions and that there will not be a proportional expansion, nor necessarily even, any expansion at all, in the size of medical schools. This calls attention to the fact that with increased numbers of under-graduate students as a whole one would naturally expect there to be an increase in the size of the academic staff of the Universities, if not precisely proportional, at least related. This is calling general attention to the fact that though the Universities' demand on the available human resources of the country was big after the war it is now slightly less but in future is likely to become greater again; but the demand for medically qualified staff will certainly not be proportionate to the total number.

4708. I think I have that particular point. The next matter I would like to draw attention to is in paragraph 7, the earnings and prospects and problems of a newly qualified member of the profession. You use an expression in the last sentence which has already been used by the Principal of St. Andrews—"To an appreciable extent therefore the Universities rely upon a sense of vocation . . ."—and a number of persons who have been giving evidence to us have been using the expression "a sense of vocation". I would like you to explain to us in what sense you are actually using it here? This "sense of vocation" we have had from different persons in different contexts and we thought we understood it but I am not quite certain whether we do now.——If I was expressing this again I think I could more precisely express it as being that a man must know that it is university work that he wants to do and that he must feel that he is going to be much happier in university circumstances doing university work than he would be by using the same qualifications elsewhere.

4709. And remuneration does not enter unduly into that consideration—is that your view?——That is not the intention of this at all, no. It is intended to say that for various reasons, which I daresay you will ask questions about presently, it is not to be expected that the rates of remuneration offered by Universities will in relation to all professions be obviously competitive. Thus where remuneration in any particular case is not competitive with remuneration to be gained by using the same qualification in another sphere it is these factors which in fact enable the Universities, notwithstanding this disparity which, of course, has got to be within reasonable limits, to command the necessary number of people with the highest qualifications. Is that an explanation which makes what was originally said more clear or less clear?

4710. On your paragraph 9—the nature and range of expenses; I wonder if you

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have any idea as to the range of the expenses that are allowed at the present time? Much has been said in the evidence before us about the differences in allowances by way of expenses.—— We had some discussion amongst ourselves before we came to meet you and during that discussion a possible ambiguity in your original question, I must confess, occurred to me for the first time. I would prefer on the whole to divide this sharply into two questions; that is, what expenses incurred by members of the academic staff of Universities are refunded to them, which is one interpretation of expense, and the other, what, if any, allowances are made by the Inland Revenue as allowances off gross income on account of expenses?

Now as regards the first they are almost entirely confined to refunding expenses actually incurred in attending conferences or travelling on university business in one way or another. They are modest in nature, they are rigorously dispensed, and the amount of expenditure incurred in this way by Universities is severely controlled. I think that so far as remuneration, or anything affecting remuneration is concerned, it can be entirely ignored. It amounts only to doing what anybody would expect to do if he asked someone to go up to St. Martin's Lane—he would give him his bus fare.

The second is not so easy to deal with because certainly I, and I think I speak here for all my colleagues, am in no position to say what particular arrangements there may be or may have been in any particular Income Tax district on this question of expenses. My own experience is that there is no general scale of expenses of any kind or character relating to university staffs, and my own experience has been that any allowance for expenses on gross income is minimal, is accidental in fact, and that it does not reach large proportions in any case. Of course, this is a matter which is in each district entirely between the individual and Her Majesty's Inspector of Taxes and there are no general rules which can be safely applied. I am afraid that except for saying that, in relation to the academic staffs of Universities, I would not regard this as an extremely significant point from this particular point of view, it would be quite impossible to give you any actual or detailed information.

4711. You see the relevance of our problem, do you not, because some of the persons who are working full time in the National Health Service are practically in the same position as the members of the university staffs?——I am trying to suggest, making due allowances for the fact that I am in no position to substantiate the suggestion by evidence, that in relation to the academic staffs of Universities an expense account is not a significant factor.

4712. No, I appreciate that. I do not think we want to pursue that further.

Can we move to paragraph 13? You deal there with the salaries that are now in force in the Universities and you divide them into three categories, the non-medical posts; pre-clinical posts and the clinical posts. The first thing that we would like to know would be an estimate of the number of persons in each category, the number of Professors, Readers and Senior Lecturers, Lecturers and Assistant Lecturers. We are very anxious to see the structure of the university staff in relation to the structure of, say, the consultant service, or anybody that we have particularly to consider. Have you any idea as to the numbers in each of the grades?——We each of us have ideas in relation to our own Universities but we have no collective information about all Universities. I thought that this question might possibly arise and, therefore, I asked the Chairman of the University Grants Committee whether from records in his possession it would be possible for him to supply you with some factual information divided into grades as between medical and non-medical staff and he told me that I was at liberty to say that he would do his best to meet your reasonable requests as regards factual information on this particular topic. For general purposes, it is of course necessarily the case, and it is an obvious truism, that those engaged in the University in teaching medical students represent in total a reasonably small minority of the total staff of the University.

4713. *Chairman*: And a diminishing one, as you said earlier.——Well, it will be a diminishing one. As regards the structure of the medical staffs, that is a

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matter upon which it is very difficult indeed for us to give you any information about Universities as a whole. Even in this case the problem divides itself fairly sharply into the pre-clinical and clinical sections of the staff and I could, I think, go so far as to say that so far as clinical posts are concerned the consultant grade is in all respects of very great importance.

4714. Numerically?——Numerically in relation to the total clinical staff.

4715. *Sir David Hughes Parry*: I notice that the pre-clinical structure of Professors, Readers and Lecturers resembles the clinical rather than the non-medical structure; is there any special significance in that?——I think, generally speaking, it has to be remembered that many members of University staffs in pre-clinical posts are medically qualified. Indeed, I should think it is still the case that the majority of the members of staffs in pre-clinical posts are medically qualified and this apparent similarity reflects a natural tendency on the part of members of the same profession to expect, if not the same, at least related or comparable remuneration.

4716. *Chairman*: I think we have a figure from other sources of 176 professors with honorary contracts and eligible for awards. Would that represent the total number of clinical professors?—— I should think that might be the case. I would not like to say definitely.

4717. It gives an indication of the approximate size.——It sounds a not unlikely figure to me. I think perhaps I ought to add they are probably not all professors because a member of the clinical staff of a University does not have to be a professor in order to have an honorary contract as a consultant.

4718. We have a figure of 298 other grades who are university staff with honorary contracts eligible for awards and we have this figure of 176 professors?——Eligible for awards?

4719. Yes.——Who added together would represent the clinical staff of the Universities who are of consultant rank.

Chairman: That is a total of some 470.

4720. *Sir David Hughes Parry*: These are normal salary ranges; I take it that they apply to women in the same way as men and there is no distinction at all?——I should think that is true, yes.

4721. That is the impression one has in the Universities, that there is no distinction as regards remuneration.—— Yes.

4722. It has been represented to us on behalf of the junior hospital grades that it is not quite fair, and that it was not so before 1948, to make charges for residence or to deduct lodging allowances. What is the practice in the Universities where posts are residential as regards remuneration? Are there deductions from salaries, or variations of salary ranges?——I find that very difficult to answer. I should think the practice varies a good deal. I know of cases where the salary is a gross salary and payment is made for residence. I also know of cases where the salary, together with the value of residence, represents the gross remuneration.

4723. Have you any other experience of that in the residential colleges? What happens at Oxford and Cambridge, could you say?——I would find it very difficult to reply to this very complex question on behalf of either Oxford or Cambridge, singly or together.

4724. *Chairman*: Sir Folliott?——*Sir Folliott Sandford*: I certainly could not say without notice.

4725. Can you say, Sir Philip, what the Inland Revenue do in assessing the value of residence in colleges? Do they take something into account?——*Sir Philip Morris*: I cannot answer this in general. I can answer it in regard to one or two cases which I personally know of. In one case they do take it into account; in two cases they do not and it is quite clear that the decision is made on the facts of the situation, that is, upon the reasons for residence, the nature of the contract between employer and employee by which residence is added to remuneration, and so on. I am not an expert on income tax but I would have thought that was likely to be the position anywhere.

4726. *Sir David Hughes Parry*: What we thought was that there might be a recognised practice in the Universities as regards deductions on allowances of this kind when a person was living in.

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——If there is, I am not aware of it. I do not know if any of my colleagues are aware of it.—*Dr. Logan*: We have very few residential posts in London but where they exist the general rule is that the salary for superannuation purposes is one thing and the actual remuneration paid is another. In other words, it usually happens only in the case of Wardens of halls of residence, but if the gross salary for superannuation purposes was £1,650, or something of that kind, the actual net remuneration with a deduction of something like £300 or so for residence would be about £1,350. I understand that in such cases that difference is not subject to income tax because the Wardens are required for the better execution of their duties to live in the halls.

4727. Have you any experience on this matter as regards teaching posts? ——We have no residential teaching posts except at the women's colleges and there I think that the practice which I have described for Wardens of halls in residence applies.

4728. *Professor Jewkes*: What is the meaning of the phrase under the subheading of "Professors" in paragraph 13? It says there:—

> "The grants will be related to basic salaries of £2,300 a year in Universities and University Colleges."

How is that related? Does it mean that the total sums made available to the University for paying Professors will equal £2,300 multiplied by the number of Professors, or if not, what is the meaning of it?——*Sir Philip Morris*: You are referring to the non-medical posts, are you?

4729. Yes.——The actual position is that the £2,300 would be regarded as the staple professorial minimum. The second sentence says that the University Grants Committee—since 1947, I think I am right in saying—had an arrangement by which there is a limited amount of money fixed as a measure of the extent to which supplementation in the case of particular Chairs can be added at the discretion of the University. The remuneration is related in the first place to the professorial minimum of £2,300 and the full range, between £2,300 and £3,000 is available for use by the University within a global financial limit.

4730. So that the £2,300 is the minimum and the £3,000 is the maximum normally?——The £3,000 is the maximum if the University can afford to pay it.

4731. How is the scale decided in these cases? Will provision continue to be made for supplementation? How is the total sum to be provided in that way decided and how is it distributed between the different Universities?——The total sum is in relation to each University.

4732. *Chairman*: It is a proportion, is it?——The total sum is determined by the University Grants Committee in relation to each University.

4733. Some will, therefore, take a bigger proportion of their salary in the form of supplementation than others, or do they all get a similar amount?—— I think I might say here that I am not sure that a member of your Commission could not give you better information about the way in which this particular pack of cards was turned out in the first place than I can! There was a big variation between Universities at the inception of this scheme in 1947 in what has since become known as permitted spread. However, more recently, the University Grants Committee has rectified the situation and the amount available for the permitted spread now is determined in relation to an average salary for the professoriate in each University taken as a whole. The sum is now arrived at by a decision on the part of the University Grants Committee as to what in relation to each University appears to be necessary and then by expressing it in terms of an average salary for the professoriate. For example, if the average salary was £2,600 and there were 30 Professors the limit of professorial spread would be £9,000—30 times £300.—*Dr. Logan*: Could I just make one point? This is not a sum of money which is specifically voted for the purpose or allocated by the University Grants Committee to each University. It is a permission to each University to use this general fund for paying more than £2,300 to non-medical professors, a permission to spend out of a block grant.

4734. What I am trying to get at really is are there any statistics showing for non-medical Professors, what proportion

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get £2,300, £2,400, £2,500—right up to the £3,000?——*Sir Philip Morris*: There is no published information on this whatever. The only office which might have the relevant information on this subject would he the office of the University Grants Committee.

4735. *Chairman*: Have you any idea at all, without being too specific, whether for instance in the non-medical posts the usual salary of Professors is rather nearer the £2,300 mark than the £3,000 mark, whereas at the other extreme with the clinical posts, for a variety of reasons, the usual salary is a good deal nearer the top limit?——I should think that is certainly the case.

4736. *Sir David Hughes Parry*: And for the pre-clinical posts it would be somewhere intermediate, about the middle between the two?——That would be correct.

4737. *Chairman*: Yes, so that on the whole there is really more of a difference between the clinical, pre-clinical and non-medical than appears from just the pure scales?——Are you now speaking of Professors?

4738. Yes.——Because for Professors there are no scales.

4739. I am sorry—I should say than appears simply from the fact that salaries in two cases can range from £2,300 and in the other from £2,500 to £3,000.—— I think at present it is universally the case that non-medical posts tend towards £2,300 and that the clinical posts tend to be at the £3,000 point.

Chairman: Thank you very much; that is what we thought.

4740. *Sir David Hughes Parry*: Are there any figures or any estimates of the manner in which the Universities have used the amount by way of supplementation of Professors' remuneration—on what principles they have heen doing it?——I think that is a very difficult question to answer.

4741. You see its relevance to us; it is a difficult matter with us too.——I would be willing to make a few comments, with which my colleagues may disagree, if they wish; and I shall now intend to speak about non-medical Professors. It seems to me that the existence of this permitted sum recognises and accepts the necessity for taking account, in determining professorial remuneration, of events and pressures of the outside world. I think that generally speaking the existence of this permitted sum is occasioned by the unavoidahle necessity of departing from what is otherwise regarded as a good academic principle of equal remuneration. It is regarded as being an opportunity to enable Universities to be more able to make good appointments in what could be regarded as highly competitive activities. I think I ought to make it clear that the discretion which is allowed to Universities is intended to he exercised by them, and thus they are perfectly entitled to exercise it in a different manner. I think I ought to explain that there is a very strong feeling in the university world as a whole that a big differentiation between one member of the academic staff and another, solely on the ground of subject, is academically to he discouraged hecause membership of the staff of the University is regarded in the University as involving the acceptance of responsibilities which go with the vast knowledge and training required in the education of the rising generation. And the view of the Universities generally is that those obligations do not sensihly change as hetween one subject and another, at least as far as the most important things related to them are concerned. At the same time Universities have been obliged—not without great reluctance—to accept the necessity for some differentiation; but they have been at very great pains to press for the retention of a discretion—within, of course, permitted limits—to exercise in a way which they regard as being most suitable to their own particular needs and requirements. That may sound a little more complicated than necessary, but in fact it is not, hecause I think it has to be remembered that Universities are very differently composed. They represent a different spread of subjects. For example, many Universities have no medical schools at all, so they are not affected hy clinical and pre-clinical distinctions. The same would apply to technological fields, which in many cases are not represented at all and in other cases are represented to a very large extent; so the problem differs as a matter of fact. This is not

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just a position of unnecessary complication arising from an academic point of view: it arises from the facts. The second point which has to be borne in mind is, as Dr. Logan reminded you, that this permitted spread, although expressed in terms of money, does not represent cash. The cost of any supplementation which is added to the basic professorial salary is a charge on general income and competes with everything else which seeks to become chargeable to general income. So the University is under very considerable limitations in exercising this discretion, and Universities have never suggested—nor would they, I think, ever be likely to suggest—that they should have anything but a limited discretion. They might argue about what the limits should be, but they would not argue against the need for a limited discretion.

4742. *Sir David Hughes Parry*: No conditions were laid down by the University Grants Committee as to the manner of the exercise of the discretion?——No.

4743. *Chairman*: Are most Professors—I am dealing entirely with the non-medical side, as I think you were, Sir Philip—employed whole-time by the University, or have most of them other sources of earned income as well?——I should say that the vast majority of them are full-time.

4744. And those that do earn outside, for instance, if it happened to be a Professor of architecture doing some architectural work for a client, or a Professor of economics broadcasting and writing articles, and so forth—is that normally brought into account in any way, for instance, in deciding the permitted spread of the University. Would any account be taken of the fact that some types of Professor are more likely to be able to earn outside than other types?——There is a danger of giving you a very frivolous answer to this, but I will not! This question of additional remuneration is a very difficult one to deal with justly. A Professor of Nordic, whose excellent qualifications are not deployable in the world except in a University, can easily write a best seller and can, by this means, attract infinitely more money than even a consulting surgeon could earn, even if he were allowed to spend his spare time operating for gain. However, I should have thought in the first case that no Professor of Nordic would regard himself as being under an obligation to take the income and royalties from his best seller into account in determining remuneration. I should think such a Professor would be somewhere down towards the professorial minimum than rising anywhere near the actual average clinical remuneration. I have given that example deliberately because that represents one limit in the structure. At the other limit there are, as you must well know, some Professors in Universities whose services are very highly sought after for a very large number of purposes, and one of the big contestants for the services of those whose ability is the highest is the Government itself. It is certainly true that the Government is never a generous paymaster in this respect, and in my own experience the Government has never yet offered enough to create embarrassment so far as my own University is concerned. In other consultant appointments I think the general situation could be explained in this manner—I think most Universities have a kind of system by which contracts of this character entered into by the professorial staff are, by one means or another, declared and made known to the office of the Vice-Chancellor or to the University, and the additional remuneration earned in this way is kept under supervision in that manner. I can only speak from my own experience, but within my own experience the additional remuneration obtained in that manner has always been within such reasonable limits that no one could regard it as being an amount which ought to be taken into account in determining remuneration. If one got to the point where one had to look at it in that way, one might easily find that here was a position of "unto him that hath most, most shall be given", because his abilities were evaluated on the most lavish scale in the outside world, and that would be an indication of how much his services were in demand. Fortunately, that limiting predicament very infrequently arises.

4745. But on the whole, in the University you would think it is quite important to keep a pretty fair relationship between the Professors in the different types of

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study?——Oh indeed we do. We should like what we call various gaps which have opened up to be kept within limits, and some sensibly closed, and if you look at the three sets of figures we have given, you will see that the opportunity was taken, on the last occasion, sensibly to diminish a number of cases.

4746. *Professor Jewkes*: That is shown in paragraph 14. May I just ask, on paragraph 13, about the permitted range? After all, it is not a very narrow one, it is £2,300 to £3,000. It is a fairly wide range. Can you give us any advice on the principles which are followed by Universities in deciding whether the figure is to be at the higher end or the lower end? For instance, why should the Professor of Nordic be placed lower—I think you mentioned he was to be at the bottom?——I think, in the first place, the actual extent to which that range can be used is affected by the permitted sum, which restricts the total amount of supplementation; and I think, in the second place, there is no actual possibility at the moment in relation to general income of the hope of this range being effectively used in the non-medical field. In the third place, I think that in many cases decisions are made on mixed criteria, and it would be an assessment on such unlike criteria as personal eminence, obvious high value of services—either to a department or of the subject to the University as a whole—and, of course, in many cases the actual nature of the subject and the work done and the responsibilities which go with it. For example, you would naturally expect a very expensive technological department, or a very expensive pure science department, with a Professor at the head of it—if the appointment had been well made—you would naturally expect him to be well up in the professorial spread on all three grounds, eminence, responsibility and the fact that he was engaged in an activity which was very highly remunerated elsewhere.—*Dr. Knox*: Could I add one point about this? Some Universities took the view when they were told, "Here is a global sum which you can spend if you can find it out of your general grant, for lifting professorial salaries above the minimum", that what they ought to do was to try to diminish the gap between medical and non-medical staff, and they divided it more or less equally between them. Other Universities took the view that what they ought to do was to remunerate more highly the people of personal eminence and the heads of big departments, and so forth. Both of these quite different criteria are in use in Universities, and as Sir David says, there were no rules laid down when this business began. That is the position today. There are some Universities with one system and some with the other—some wanting to close the gap between medical and non-medical, others wanting to give special salaries to certain special people.—*Dr. Logan*: There are even wide variations additional to that. In London the general view was that part of this permissible grant should be allocated among all Professors and the rest used for this purpose, and one Institution at least has used the rest to give salary increases on a pure seniority basis. There are almost as many ways of dealing with this problem as there are those who have to handle it.

4747. *Chairman*: And that is a satisfactory position, that there should be many ways and some flexibility in dealing with this according to circumstances, whether geographical or at any point of time?——I think it is a very good thing to leave the discretion with the academic institution.

4748. *Sir David Hughes Parry*: Within the limits prescribed by the University Grants Committee.——Yes, to settle the matter in relation to its own needs.

4749. *Chairman*: Could you give us just an idea as to the size of this permitted sum in relation to the total salary for Professors? This is given to the Professors, is it not?——*Sir Philip Morris*: Yes.

4750. Is it of the order of 10 per cent to 15 per cent of the sum paid out to Professors, the amount that can be spread at your discretion?——Dr. Aitken says 12 per cent, but I would like to do some arithmetic before I give you my answer; it is probably of the right order; it is between 5 and 15 per cent.

4751. *Sir David Hughes Parry*: It may be that we could get the actual

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figure from the University Grants Committee.——Well, it is capable of being worked out theoretically.

4752. *Chairman*: Is it in fact calculated or allocated on that hasis, as a percentage?——No.

4753. It is not: it is a sum which has no relation to anything in particular? ——It is perhaps a more complicated calculation than one might think, but it is capable of being worked out theoretically.——*Dr. Logan*: You can get the information from the U.G.C. We are not in a position in our own University to know what is happening elsewhere. Some of us may have shrewd suspicions of what happens at other institutions, but we do not know what happens over the whole scheme. It differs from University to University.

4754. *Professor Jewkes*: One point I am particularly interested in arises out of a discussion we had this morning with a witness who was talking about the relationship between clinical and preclinical salaries—medical people in Universities. The moment one begins to discuss that, the question of the relationship between pre-clinical scientists and other scientists comes up. I was wondering whether you oould give us any indication as to whether, in tbe operation of the permitted limits, the different Universities have tried to increase science salaries in relation to professorships in the arts, because it affects the relationship between the preclinical salaries and science salaries. Is there any attempt to widen the gap between science and the humanities?—— The University Grants Committee would have the information. I am perfectly willing to give you the position in London, however, where I would say that the average salary of a science professor is about £100 more than the average salary of an arts professor—but that is only the situation in London.

4755. But in most cases the gap would be small?——*Sir Philip Morris*: Again, we only know the situation in each of our Institutions. It rather masks the information which you want if it is dealt with in terms of averages, because the average itself represents oonsiderable variation within the class of whicb it is an average.

4756. And the position may differ widely from University to University? ——Yes.

4757. *Chairman*: But broadly, I think you have said already that, in general terms, most of the clinical professors will he on the £3,000 or very near it; that most of the non-medical people must be much nearer to £2,300 than £3,000; and that the pre-clinical ones are somewhere in between.——I do not think anyone would disagree with that.—*Dr. Logan*: It is true, hut in London, owing to the difference of the consultant grade salaries, there are increments for clinical Professors ; so a Professor will normally go to the maximum. In the case of a non-medical Professor, his chances of getting £3,000 are very limited indeed.

4758. *Sir David Hughes Parry*: May I just ask one more question on paragraph 13? It has been represented to us that there ought to be extra payments for administrative duties. Are there any examples in Universities of extra payment to members of their staff for purely administrative work because it adds to the responsibility and work? It is a question of extra remuneration outside the scales. ——*Sir Philip Morris*: Of extra remuneration, I expect there are cases: whether they are outside the scales is a separate issue, because they could easily be inside the scales and still receive extra remuneration for extra administrative duties.

4759. Yes, I appreciate that.——In my own case, with the exception of certain administrative duties which are not related to the departmental position of the person concerned, there are no such payments for administrative responsibility. Where they exist they are very small in character ; they are honoraria and relate to a certain state of affairs. For example, I know of a case where a person receives an additional payment of £100 whilst he occupies a job, which he will only occupy for as short a time as he can, and will willingly pass on the work and the £100 to somehody else at the earliest opportunity. That is the only case of which I have direct knowledge, but I helieve there are examples of administrative duties being taken into account in this manner in operating the permitted professorial spread, and that would be a oase of supplementation being given over and above £2,300, on account of administrative duties.

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4760. The examples are not many? ——No.

4761. *Chairman*: Would that be true at Oxford, Sir Folliott Sandford?——*Sir Folliott Sandford*: You would find a number of cases at Oxford.

4762. Would you also find people who had college responsibilities getting additional remuneration for work they did for the University?——Yes.—*Dr. Logan*: But in the wide run of the cases, it is nearly always Professors who have these administrative duties. If a non-medical Professor is paid for administrative responsibility, that must come out of the permissible grant. You cannot pay for departmental responsibilities over and above the permitted amount. It is one of the factors taken into account in most Institutions in quoting the permissible salary.—*Sir Philip Morris*: In relation to Professors, it would be a different method of arriving at the utilisation of the permitted spread and not an addition to it.

4763. I am trying to establish this point, for instance, in relation to superintendents in mental hospitals in Scotland, where it is suggested that because they are at the same time medical staff and superintendents, as it were, they should earn rather more than if they were simply consultants without the administrative side as well. That is the kind of parallel in your case, so far as you can say for Professors—there is a bit of adjustment within the ceiling?——Yes.

4764. But it would count for something?——It might.

4765. Yes, but not for very much.—— *Dr. Knox*: In at least one Scottish University, it would count for nothing.

4766. *Sir David Hughes Parry*: Now may we move on to paragraph 14—alteration of remuneration since the war. Are there any records of the position, say, in 1938? We have 1949, 1954 and 1957.——*Sir Philip Morris*: These are three revisions of academic remuneration which have taken place since the war, and that is why these three are given. They represent the whole of the post-war story. As far as pre-war salaries were concerned, the position of remuneration in Universities was entirely different. There were then entirely individual arrangements between Universities and their staffs. The 1949 position really represents the first systematic settlement of ranges of salaries and salary scales for Universities as a whole. If you should wish to make comparisons between this state of affairs and the state of affairs which existed pre-war, you would necessarily have to go to the University Grants Committee for the information. There is no reason why the Committee of Vice-Chancellors would wish to have it, and there would be no ordinary manner in which that information would collect in the office of the Vice-Chancellors; but such information as there is, the University Grants Committee would certainly have.—*Dr. Logan*: There are certain statements made in the development reports of the University Grants Committee about average salaries at the date of the report, and so forth. There is a figure for 1938-39 in the U.G.C. development report for 1945-47.

4767. *Chairman*: Yes, there is just one further point on that. Again, when we were talking to the Medical Research Council this morning it emerged that before the war the salaries of clinical and non-clinical people were virtually the same, and by the end of the war there was a certain difference of about 6 per cent. Now, of course, there is a very large difference in the ceilings because of the operation of merit awards. Quite apart from merit awards, there has been a difference since the war in the non-medical, pre-clinical and clinical posts. Do you know whether that was so before the war all the way down?——*Sir Philip Morris*: I think it would be very difficult to answer, and one has to remember that in a large number of medical schools there were many fewer full-time consultants on the staffs of Universities. The pattern of organisation has changed so much that comparison between now and before the war would be to a large extent false for that reason.

4768. *Sir David Hughes Parry*: In the medical field, that is?——Yes.

4769. Now I wonder if you would explain this: when I saw the dates 1949, 1954 and 1957, I thought there was something significant as to why the reviews should take place in those years. Could you give the background to each one of them?——I should think that in all probability the 1949 review was occasioned by medical remuneration.

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Certainly medical remuneration in relation to the Health Service triggered it off, if it did not actually completely cause it; but I would say it would be perfectly fair to regard there being a close linkage between medical remuneration and these reviews, so far as 1949 and 1954 were concerned.

4770. 1954 is the same, is it?——Yes; I was speaking both as regards 1949 and 1954, but the same is not the case with regard to 1957. The 1957 review was occasioned by two factors operating, I think, unequally. The first was general inflation, with the general cost of living justification, but the other was a recruitment factor. It was felt very strongly, and it was subsequently—to the satisfaction of everybody—proved sufficiently, that recruitment was suffering and was likely to suffer unless there was a substantial change in the remuneration of the academic staff at Universities, and particularly at the bottom and at the middle.

4771. *Chairman*: How long did it take from the time you started to establish that fact and the time in 1957 when the changes were agreed? Was it a matter of months?——So far as arguing and establishing what it appeared should be done was concerned, the time occupied was relatively short. I can put it at probably three to four months. As regards the hiatus before really serious discussions between the parties took place, there was a much longer period, and subsequent to the serious discussions to arrive at a pattern which was capable of being justified, the time which was taken by the Treasury finally to agree to it was somewhat protracted.

4772. *Professor Jewkes*: Do you happen to recall the date, Sir Philip, in 1956? The dates happen to be important for our purpose.——*Dr. Logan*: I can give you the general picture. At the beginning of 1956 it was felt that the situation was likely to arrive where a change in salary structure was necessary. I think the informal discussions, to which Sir Philip referred, took place between about June and October. The announcement was made by the Chancellor of the Exchequer in March, 1957, and I regret to say that the salary increases did not come into operation until the following 1st August.

4773. Did anyone tell you, as they told the doctors in the same period, that the country was in a serious economic crisis and that there was a grave danger of inflation if the salaries were raised?——*Sir Philip Morris*: It was said on both sides that there was very grave danger of inflation. As regards the first, I am not sure that the argument was used very much in my hearing, but no doubt it was an argument which was used fairly strongly as between the Treasury and the University Grants Committee. That could be the case, and as to that I think your question should be addressed elsewhere.

4774. *Professor Jewkes*: There is another point. You made the interesting comment that the 1949 increase and the 1954 increase were probably triggered off by earlier increases in the remuneration of doctors. Do you feel that the 1957 increase triggered off a demand on the part of doctors for an increase in their remuneration?

Chairman: I think the dates do not quite fit.——I should have thought the action on account of the Universities occurred after the doctors' application had already been triggered off.

4775. *Professor Jewkes*: I am trying to see how far they affected each other. ——I should say they were chronologically arranged in the reverse order, so that causality could not be inferred. I would think that these were activities which were related but not directly.

4776. A current occurrence but different treatment? The Universities got their increase, but the doctors did not.——I suppose one has to see the end of this matter in order to turn it into a relative advantage or disadvantage.

4777. *Sir David Hughes Parry*: You have now taken us almost to the next matter, namely the methods of assessment of salaries. A new scheme, I understand, was introduced about two or three years ago. It determined the range of university salaries—is that right?——Yes.

4778. I wonder if you could give us a general description of it, together with any comment that you would like to make on the way it is working—if it has been working—since it was instituted.

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—Yes, I think I must he allowed to begin by a short explanation of the general situation. The Universities are independent, autonomous authorities, and each University is an employer; there is no federation of employers. The Universities are governed in such a manner that they have a large measure of self-government, and those who receive remuneration from Universities are themselves concerned, to a greater or lesser extent, according to the occasion and the subject matter of the University, in the government and administration of the University which they also serve. There is therefore a very special position arising here. In the second place, there is an Association of University Teachers. That Association, while representing some members of the academic staffs of the Universities, is not itself recognised as a union, but it does feel itself, and has the right, to have views and to make representations on the subject of remuneration at large. During 1953-54, and especially during 1954, the Association of University Teachers felt itself under an obligation to press very hard for some kind of recognition in the machinery which was to be used for the purposes of reconsidering, and, if necessary, revising remuneration. After a good deal of discussion—and not without some difficulty—it was eventually decided by the Chancellor of the Exchequer in 1955 that the Association of University Teachers ought to have an opportunity either of approaching the University Grants Committee on the grounds of the inadequacy of the remuneration and/or of being consulted before the University Grants Committee made submissions to the Treasury in relation to the remuneration of the staff of Universities. Eventually the University Grants Committee, after some consultation with the A.U.T.—and with the Vice-Chancellors' Committee, I think —decided that the Association of University Teachers should have the opportunity of approach to the University Grants Committee on the question of salaries at any time; and that the University Grants Committee should feel itself under an obligation at least to give the Association of University Teachers the opportunity of expressing its views before it made representations about salaries. But that was all subject to the continuing right of the University Grants Committee to consult with the Committee of Vice-Chancellors, the best available body to consult with them and advise them about general matters affecting the remuneration of staffs of Universities. It was hoped, at the same time, that the Vice-Chancellors' Committee would find itself able to make some arrangement with the Association of University Teachers by which those two bodies found themselves able to have, without any commitment on either side, general consultations on the subject of academic remuneration. So the present situation is that the Vice-Chancellors' Committee does continuously generally consult with the Association of University Teachers on matters affecting salaries; and also on certain other matters, but I do not want to mention those, because it would distort the picture if I did. Those informal consultations are carried out on the basis of sharing views, and of avoiding unnecessary differences, but neither side is prevented by anything which takes place in such informal consultations from making just what representations it feels it ought to make to the University Grants Committee. In practice, the bodies, both being reasonable bodies, would feel themselves under an obligation to behave with strict decorum on a matter of that character. And on this last occasion they were carried out in such a manner that I think it would be true to say that we knew pretty well where each other stood at all relevant times. The University Grants Committee is finally responsible for making representations to the Treasury and eventually, if necessary, of producing a reasoned case for the representations which are made, and subsequently for passing on the result to the A.U.T. For this purpose, the University Grants Committee sits in a different manner from the way in which it sits for all its ordinary business, but as to that you would probably wish to ask the Chairman of the University Grants Committee himself. That, broadly speaking, is the picture. Nobody, I think, who had the arrangement of matters at his disposal, would ever have invented this particular way of doing things; but you will see that it has grown out of difficult circumstances. It would, however, be true to say that it has

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worked not unsuccessfully, but whether it worked not unsuccessfully would be influenced, I think, both by the prevailing circumstances and also by whether the outcome appeared to be successful on the one hand, aud on the other hand it would be very much influenced by the actual persons who happen to be chiefly engaged on both sides at the relevant time. I am sorry to have explained that in such an apparently complicated manner, but it is my duty to make it abundantly clear that the arrangements are not arrangements of joint negotiation; they are not the customary arrangement of joint negotiation found outside—nor could joint negotiation be arranged without making a lot of alterations to the status and position of the Universities, and in a lot of other directions. This is the nearest approach we can get to some form of joint consultation—with a small j and small c—and it is the best way in which we can get the various bodies in a relationship to each other which is regarded by each of them as being reasonably satisfactory.

4779. *Professor Jewkes*: Still on paragraph 14, I was going to ask you, Sir Philip, about a matter which I think you started to raise yourself some time ago. If you look at paragraph 14 it is quite clear that, as between the three groups, non-medical, pre-clinical and clinical, there has been a movement towards equality of earnings. That is to say, the non-medical earnings have gone up 44 per cent, the pre-clinical by 20 per cent and the clinical by 9 per cent. Has that been deliberate policy?——I would say yes, on the whole, arising rather in this manner—that the position as regards remuneration of the academic class generally was admittedly extremely unsatisfactory in 1949. It was, I think, fairly generally concluded that, in relation to medically qualified people, there had got to be a very considerable improvement; but it was felt at the time to be very difficult to let what was a good argument in relation to medically qualified people apply directly to other members of the academic staffs at Universities. In 1954 a similar state of affairs existed, with a very slight difference. The general pressure of opinion in the Universities had begun to have an effect, and that general pressure was towards a greater degree of equal remuneration between people who were members of the same academic community and who had in many respects precisely similar functions to fulfil, though in relation to different subjects. In 1957, the basis of the revision was different because it was much more on the grounds of recruitment and of guaranteeing that the Universities would be able to obtain the necessary staff to make the Government's expansion policy possible. The pressure on Universities to do something to remove the big differences between medical and non-medical remuneration had even more force on the 1957 occasion than previously. It would not be untrue to say that in 1957 part of the objective was deliberately to eliminate to the maximum possible extent the basic difference between the pre-clinical and non-medical remuneration.

4780. *Chairman*: With the recruitment position as you have explained it during the next ten or fifteen years, with a great expansion in the Universities but not in the medical schools—do you envisage that it will become even more important to reduce the differentiation?——The differentiation, except in quite unimportant respects, between the pre-clinical and non-medical has been practically eliminated except for the professorial rank. The position as regards medical remuneration is that in the 1957 revision the position as regards full-time medical staff in Universities was not unsatisfactory in relation to the then level, and even to the present level, of consultant remuneration. Of course, if the consultant remuneration changed very considerably we should, to a large extent, find ourselves back in a position analogous to the 1949 position.

4781. But just below the Professors are the Readers and Senior Lecturers, Sir Philip. I am not absolutely clear, but I think the Senior Lecturers in the non-medical posts have a range of salary varying to a maxima of £2,250. In pre-clinical, it is with varying maxima up to £2,250, and in the clinical it is £2,550. It is not distributed evenly among Readers and Senior Lecturers.——No, but it is very small in relation to the clinical posts. Of course there is a very big gap still, and generally speaking, with regard to Lecturers and Senior Lecturers and Professors in the clinical ranges, their salaries can overlap: for example

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there is no reason why a Reader who is a clinician should not be paid more than a Professor.

4782. Should not the same thing apply for Reader and Senior Lecturer as to Professor? That is to say, on the whole in the clinical posts, they are nearly at the top end of the scale—the top end of their various maxima mentioned would normally apply; whereas in the non-medical posts they would be nearer the bottom end of the maxima. If you take the Lecturers in the pre-clinical grades, you say there is a range of £1,650 to £2,250—which is quite a range. Would you say that most of the Lecturers in the pre-clinical posts are the same?——I would not say that general difference was valid at the Readership and Senior Lecturer range, as between non-medical and pre-clinical, but the Lecturers are *sui generis.*

4783. *Professor Jewkes*: You thought it was a good academic principle that there should be equity of payment between the teachers of the same grade in different faculties. Can you just enlarge on that? Why do you think it is a good principle?——I wonder if you would like to make it easier by taking out the word "good"? I argued that it was a well-established one.

4784. Yes; then why do you think it was well-established?——I think it springs in the first place from the fact that Universities developed from being small and domestic close-knit communities, in which they regarded their obligations as being more on an equality because of the human responsibilities they have—those with whom they work and those who they teach—rather than as being unequal because of the kind of subjects which they used for the purposes of teaching. I think that is where it begins. It goes further; because I think that Universities generally have wished to avoid big social disparities within communities, and they have wished to prevent that state of affairs occurring in which they have very different kinds of manners of living going on amongst people who really should be working closely together. I suppose, shortly, one of the arguments which is strengthened by the first two is if there is competition anywhere, of course it does assist you whenever you wish to argue that the general level of remuneration should be raised. I think that is being quite fair to the argument, but I daresay that possibly my colleagues may like to differ on this, and if they do I think they should say so.

4785. *Chairman*: Yes, please.——But that is the position as I understand it, speaking as one who has comparatively recently come into the university world, and has for himself tried to find out the importance of this particular phenomenon.

4786. *Sir David Hughes Parry*: I wonder if I could take you a step further? It has been represented to us very strongly that the merit award should be extended to those who work in the scientific medical field, although they are not registered for medical purposes. Would there be any repercussions or reactions in the university world if there was an extension?——We have considered this on many occasions, not without anxiety. I think that, in accordance with the point of view which I have tried to explain, the merit awards would not be, as you would expect, very attractive as far as the Universities were concerned at all. They do represent a fairly substantial variation between some members of the staff of Universities and the rest. At the same time the merit awards, as they are at present operated, have been simply by the operation of time accepted as being both logically founded and reasonably and sensibly limited, and I think nowadays most people, including, for example, less well remunerated Vice-Chancellors, have got used to the idea of a full-time clinician getting a higher total remuneration, on the grounds that he has all the pain and anxiety and worry of actually carrying out clinical duties in dealing with actual patients. That seems to represent a clear, acceptable and "justifiable" criterion. It is the cause of some embarrassment and anxiety, but at least it is embarrassment and anxiety within reasonable limits. An extension of the merit award system beyond those who were actually put to the pain and suffering of dealing with clinical work and actual patients, would certainly increase our difficulties and embarrassment and would certainly cause problems for us. We have thought very seriously whether it was either possible for us, or indeed our duty, to try and find some other alternative proposal which would be free from some of these difficulties and in

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itself defensible; but we think that we are neither responsible for making any such suggestions nor if we were, that there were any suggestions that we could make. We have been forced—not without difficulty—to the conclusion that the merit award system, as it now exists, though embarrassing, is tolerable; that its alteration or extension might be even more embarrassing and consequently intolerable, and that it would certainly have repercussions, but those repercussions would he very difficult to forecast unless we knew the nature of the changes.

4787. *Chairman*: Sir Philip, you were talking to Sir David about the extension to a fresh class of recipients; but would your answer be the same if we had heen asking you what you would think of increasing the amount of a merit award or increasing the proportion of those now eligible who might obtain it?——It would not be quite the same but in some respects it would be similar. A considerable increase in the incidence of merit awards or in the amount would have such an effect on the actual remuneration that of course it would have a repercussion of some kind—how big would depend on the size of the extension and the amount of increase—on the salaries position generally. It would not he the same because the departure from the present criterion, hy which merit awards are confined to those who are actually responsible for the treatment of patients and have all the disadvantages and responsibilities and the rest that goes with it, would of course introduce another factor altogether.

4788. We have heard, Sir Philip, that doctors who are not just right within the National Health Service but who are employed in other ways such as medical officers of health are anxious to be treated not as members of the particular community of civil servants or whatever it may be in which they work out as doctors, and remunerated accordingly. On the whole, in the University you favour a university community where all Professors can look to each other with an equal amount of respect and think of themselves first as Professors?——That I think would be true.

4789. That really is the position of the Universities as a whole?——Yes.

4790. And, Dr. Aitken, that would on the whole go for the clinical faculties, would it?——*Dr. Aitken*: I think, Sir, I would rather put it this way, that there are two forces operating, hoth of them quite strong and important. One is that we wish a university community to be a community of people and not just an aggregation of persons coming in and doing their jobs and going home—and these considerations about salary have an important bearing on whether they do become a community of people; we take them very seriously. But the other force that we have also to take very seriously is the problem of recruitment subject by subject and faculty by faculty in the light of the availahle numbers of good people in each line of country and the demands for them and the rewards offered to them outside. It is obvious that that forces us, and has forced us, into a differentiation of salaries between medicals and non-medicals and even, as you heard, to some differentiation of salaries within the non-medical professorial group. I hope at least that all, or very nearly all, the justifications we gave for differentiating salaries among the non-medical Professors —we had a list of them a little while ago —are ultimately referable to the problem of competition outside and the need to attract to the University a sufficient number of top level people.

4791. Might it be that some entirely different Chair, for instance of nuclear physics or engineering, because of competition from industry and outside generally, had to be dealt with in the way that clinical posts have had to be dealt with in the past, and would that be a very great trouble if it arose?——I think it is not unlikely that in the near future we may find that it is difficult to maintain in some of the engineering Chairs the level of quality relative to the engineering profession outside that now obtains between our medical professors and the medical world outside. That is to say, the problem that you adumbrate may easily face us quite soon.

4792. Would you feel that is something you could deal with more easily, without making the University less of a community, than, if you had to give, for instance, an extra £1,500 a year, say, which is less than some of the top medical Professors get altogether, over other Professors? Would that upset the whole

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university structure?——The point of compromise would move a little, but it would not upset the whole thing if it were sufficiently limited in extent. My initial point is that we have got to accept the resultant of two forces and we do not want to go too far from the middle path.

4793. *Professor Jewkes*: How far might you be forced away from it? Take the position of science and scientists. If it is generally accepted that there should be more scientists and science teachers in the Universities might it not be a good thing to have an increase in the remuneration of scientists without an increase in the remuneration of other Professors? Otherwise if you gave them all an increase it would frustrate the scheme, would it not?——That is something we would have to examine in the light of the situation at the time.—*Sir Philip Morris*: I am not sure that it really frustrates the scheme because at any particular time at which this is done these are not interchangeable units and cannot compete with each other for the same post.

4794. But in so far as they are interchangeable units?——Originally?

4795. Yes.——In so far as they are interchangeable units; but in a number of cases they are not interchangeable units, so it would theoretically be perfectly possible in the short run to raise the salaries of all members of the academic staff on the grounds that it was absolutely essential to raise some. It would be theoretically possible in the short run.

4796. *Chairman*: Provided you could get the money?——Yes, I mean in relation to this question of achieving the object.

4797. *Professor Jewkes*: We are always being told it would be easy to divert people from humanities to science without anyone suffering.——It takes a long time. As everyone knows, the diversion of people from one field of activity to another involves a totally different time factor from, for example, changing from employment in a University to employment in an industrial firm in the same activity. They are really not in *pari materia*, the two problems, are they?

4798. I am an economist and I suffer from the disadvantages of my profession, but surely if one thought in terms of getting the most rapid increase in the number of scientists in the Universities, both teachers and undergraduates, it would be better to raise the remuneration of the science teachers without raising the remuneration of the people in the humanities, would it not?——The long-term effect of doing that might increase the number of people who had directed their course towards science teaching in Universities, but as between people who offered themselves for appointment in science posts and non-scientific posts it would have no immediate effect whatsoever between those two. It would give the Universities a better position possibly because the remuneration was higher in relation to other scientific employment.

4799. *Chairman*: But even taking the long-term effects, Sir Philip, is it not normally so that a dramatic change in the relativity would be more likely to have a marked effect on the one hand in attracting recruits and on the other hand in upsetting the university community, and that a comparatively small or gradual change would cause much less upset in the community of people but would not have quite the same effect in strength? It is rather difficult to get both.——Universities would have to be, I imagine, always reasonable enough to recognise the necessity on occasions for some differentials, but they would wish the general policy in the long-term to return to at least a middle course, and they would not be disposed to accept that, in order to attract from one field of activity to another field of activity, a big change of remuneration could in the nature of things be justified. They would accept that some change of remuneration might conceivably be justified by the necessity over a longer term to direct parents' and boys and girls' interests in different directions, and that might indeed operate. But if the Universities themselves, for example, were asked to operate a scheme of the scale, character, scope and weight of the merit award system as applied to clinicians it would be, I should say, beyond the limits of tolerability and would be exceedingly disruptive.

4800. Looking to both the areas over the next generation shall we say, are you on the whole wanting to influence fewer people towards medicine and more to some of the other sciences which are linked together, so far as can be seen? For instance, the new Churchill College

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Witnesses

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S. G. M. FRANCIS, M.B., Ch.B.
C. BAINBRIDGE, O.B.E., M.B., B.S., B.Hyg., D.P.H.
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P. W. PETRIE, O.B.E., M.B., Ch.B., D.T.M. & H., D.P.H.

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MEDICAL SUPERINTENDENTS' SOCIETY

G. MCCOULL, O.B.E., V.R.D., M.D.
M. J. BROOKES, M.R.C.S., L.R.C.P., D.P.M.
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Questions 4908–5031

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TWENTIETH DAY

Thursday, 19th June, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

*MRS. K. M. C. BAXTER
MR. J. H. GUNLAKE, C.B.E., F.I.A., F.S.S.
SIR DAVID HUGHES PARRY, Q.C.
SIR HUGH WATSON, D.K.S.
MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)
MR. J. B. HUME (*Assistant Secretary*)

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

(i) The quality and quantity of recruits (*a*) offering themselves and (*b*) accepted for training as medical students.

(ii) The quantity and quality of newly qualified doctors.

(iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.

(iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).

(v) The position and prospects of a newly qualified doctor.

(vi) Any trend to excessive resort to certain branches of the profession at the cost of others.

(vii) The relative advantages and disadvantages, financial and otherwise, of service as:—

(*a*) a principal in single-handed general practice,
(*b*) a partner in general practice,
(*c*) a whole-time consultant in the National Health Service,
(*d*) a part-time consultant with the maximum number of sessions,
(*e*) a part-time consultant with only a few sessions,
(*f*) a Senior Hospital Medical Officer,
(*g*) a doctor in any other sort of practice or employment.

* Afternoon only.

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(viii) The difficulties encountered by members of the registrar grades.

(ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.

(x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.

(xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.

(xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.

(xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.

(xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.

(xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.

(xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.

(xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.

(xviii) Specific proposals for medical remuneration.

(xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.

(xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.

(xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

SCOTTISH ASSOCIATION OF MEDICAL ADMINISTRATORS

Evidence for submission to the Royal Commission on Doctors' and Dentists' Remuneration

PREAMBLE

1. This memorandum is concerned solely with the remit of the Royal Commission as it applies to the terms and conditions of service of members of the Scottish Association of Medical Administrators. Our members work in the closest co-operation with their medical colleagues in all branches of the National Health Service and at one point in our discussions we considered submitting evidence covering a much wider field. Memoranda are, however, being submitted to the Royal Commission from all branches of the National Health Service and it now seems clear to us that no very practical purpose would be served by repeating evidence being brought before the Royal Commission from other and more appropriate sources.

2. We do feel, on the other hand, that there is a great need to clarify and re-appraise the position of Medical Administration in the National Health Service. This need is most clearly seen in reference to the position of the whole-time Administrative Medical Superintendents of Hospitals.

3. It will be found that in this Memorandum we keep coming back again and again to the position of these Medical Superintendents. What applies to them applies also very largely to Medical Administration in the National Health Service as a whole, and if the position of these doctors working in hospital administration is secured much will have been done to clarify and establish the position of Medical Administration in the National Health Service, at least so far as Scotland is concerned.

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Description of the Association

4. The Scottish Associaion of Medical Administrators was founded* "to maintain and develop medical administration within the National Health Service; to provide opportunity for Medical Administrators to meet and discuss matters of clinical and administrative interest; and to foster training and instruction in Medical Administration."

5. Membership is open to Medical Administrators in Scotland from the Department of Health, the Regional Hospital Boards and the Hospitals. There are some eighty doctors eligible for membership and the main correspondence of the Association goes to them all. The paid up membership is forty-five. Meetings are held quarterly and are attended by up to forty members—the average attendance is twenty-five. The meetings are held in different hospitals in the five regions of Scotland in turn and opportunities are taken of seeing and discussing new developments as they occur.

6. The Council of the Association has a President, Chairman, Vice-Chairman, Secretary and Treasurer and ten ordinary members. They are chosen so as to be as representative as possible of the five regions and of the different kinds of Medical Administrator forming the membership of the Association. The 1956-57 Council has 7 Medical Superintendents, 2 Physician Superintendents, 2 Senior Administrative Medical Officers of Regional Boards, 2 from the Department of Health and 1 Deputy Medical Superintendent—geographically it covers 2 from the North-Eastern Region, 3 from the Eastern, 3 from the Western, 4 from the South-Eastern and 2 from the Department of Health. When appointed, one of the Council members was from the Northern Region but has since transferred. (Appendix A.)

Historical Background of Scottish Association of Medical Administrators

7. The Association came into being in 1954. It was formed from the Scottish Branch of the Medical Superintendents' Society and when it was formed membership was widened to include in addition to Medical Superintendents,* "other Medical Administrators within the National Health Service."

8. The reasons for this secession are not hard to find. By 1954 the attitude to Medical Superintendents in England and Wales had become so different from that in Scotland that separation was the logical step. It was a step understood and agreed to by Medical Superintendents on both sides of the border.

9. By 1954, in England and Wales, Administration was coming to be regarded as a profession of which hospital administration formed a branch. This meant that a training in catering or accountancy with secretarial and administrative experience could form the basic training for a hospital administrator on which background he could learn whatever further skill and modification hospital administration might require. As a result of this attitude Medical Superintendents were being replaced in England and Wales by Lay Administrators. Bradbeer bears this out by the falling figures for Medical Superintendents (Bradbeer paras. 48 and 49) and in particular points out that by 1952 only eight full time Medical Superintendents were left in England and Wales.

10. In Scotland the feeling was and is quite different. Here we feel that since a Hospital is for the care of patients, and since the care of patients is a medical responsibility, medically trained men are best suited to administer the hospitals: in fact, that Medicine is a profession within which Medical Administration has a logical and recognised place.

11. The difference between the two systems has other features of importance. In England and Wales Medical Superintendents are still appointed to some hospitals. But such Medical Superintendents are not Medical Administrators in the Scottish sense. They are part-time administrators with a main interest in some clinical specialty. This concept of Medical Administration is made clear in Bradbeer(8) para. 72, which says—"The medical administrator must be a consultant in active practice . . . we do not think he should be required to give more than a reasonable

* Extracted from the Constitution of the Association.

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other Medical Officers. He thus merits extra remuneration over and above his clinical colleagues and without such extra remuneration it will continue to be difficult to fill these posts.

xvi. With regard to *financial stringency* it is clear from what has now been said that Medical Administrators as a class have, up to the present, been treated as poor relations and in comparison with their clinical colleagues suffer financial stringency. A clear example of this disparity is seen in the fact that the top salary for the three highest Administrative Medical Superintendents in Scotland is £1,000 less than the top of the Consultant salary scale without Merit award. In the days before the National Health Service the Medical Superintendents were more adequately paid and often had in addition to their salaries a free house with light and fuel and, especially in Teaching Hospitals, an entertainment allowance.

xvii. *The special considerations to be taken into account when thinking of the remuneration and recruitment of Medical Administrators* and especially of Hospital Superintendents, include these: the Medical Superintendent is a specialist requiring sound clinical knowledge so that he can fully appreciate the outlook of other members of the Medical profession whether in hospital, public health or general practice: the Medical Superintendent is the person in hospital who carries ultimate responsibility. Other considerations mentioned by members are the Medical Superintendent's responsibility for entertainment, the length of his experience and training and the high ethical standards very properly required of these officers.

There is considerable anxiety about the future recruitment of the right kind of doctors for Medical Administration. It is felt that the establishment of some three training posts in the Hospital Service in Scotland to give insight into the work at Departmental, Regional and Hospital levels will help this, but again the question is clearly related to promotion prospects and salary scales and there is an obvious need for promotion which is both competitive and rewarding.

xviii. *Specific proposals for the remuneration of full-time Medical Superintendents* in the General Hospitals of Scotland have been prepared. These proposals can well form the basis of scales for other grades of Medical Administrators.

In Scotland the responsibilities of these Medical Superintendents were assessed on the number of beds in the hospitals and the number of individual hospitals under his care. On this basis the general hospitals were graded into 6 classes. The present salary scales for these classes are given in an appendix to the Henderson report. Following the issue of that report the Scottish Association of Medical Administrators prepared fresh scales to conform with recommendation 6 (Henderson report page 22).

"The salaries of Medical Superintendents in hospitals should be increased so that the amount paid to the posts of greatest responsibility compare broadly with the salaries paid to consultants".

In drawing up these scales the Association has accepted for the present the existing grading of hospitals. The scales prepared are as follows:—

Group 1.	(3)*	£2,750 x 100—3250.
Group 2.	(3)	£2,650 x 100—3150.
Group 3.	(7)	£2,550 x 100—3050.
Group 4.	(9)	£2,350 x 100—2850.
Group 5.	(3)	£2,050 x 100—2550.
Group 6.	(2)	£1,850 x 100—2350.

These scales are based on consultants' salaries as at April 1st, 1957, and should be subject to revision so that the ceiling scale in Group 1 rises as that of the Consultants rises and that the ceiling scale in Group 6 remains appreciably higher than the ceiling for S.H.M.O.'s.

The Deputy Medical Superintendents are at present paid on a scale of two-thirds that of the corresponding Medical Superintendent and no change to that relationship is at present proposed.

* The number within the brackets is the number of appointments in that group.

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xx. In considering the *arrangement for negotiating salaries* it is contended that this Association should be included in the machinery for discussions and negotiations. It is also stressed that the salaries of all medical officers within the hospital service should continue to be considered by one and the same Whitley Council.

xxi. In commenting on *factors other than remuneration* which are affecting the contentment of doctors working in the sphere of Medical Administration, two points were brought out: they have financial implications and so are perhaps not totally unrelated to remuneration.

(1) There still are anomalies in respect of charges for emoluments and amenities —a more liberal attitude in such apparently small matters would be well worth while. Some of these anomalies are inevitable but it is felt in particular that where a Medical Superintendent is expected to entertain Hospital guests he should have an entertainment allowance.

(2) Some members have felt a certain insecurity of status and while this will be clarified if the Henderson report is implemented, especially in regard to recommendation 4 which says that the Medical Superintendent 'ought to be the co-ordinator of all activities within the hospital' there are many who maintain that status cannot be dissociated from remuneration and that to maintain his position as Superintendent and Co-ordinator the occupant of such a post must be properly rewarded financially.

Comment

19. In spite of the support for Medical Superintendents given by the Scottish Consultants and Specialists, the Guillebaud report, the Henderson recommendations and the W.H.O. documents quoted in Appendix B, there still is anxiety in Scotland lest the English system of lay administration be imposed on the Scottish Hospitals.

20. The Henderson report in paragraph 15 fails to make the Scottish position in this matter clear. That paragraph states that 22 Hospital Groups out of 84 have medical superintendence and so the paragraph concludes "it can be seen that at present only a minority are directly concerned with the appointment of administrative medical superintendents". The statement as it stands is true but the comparison of 22 Boards with 84 as the possible number is misleading and might even suggest that 75 per cent. of the Boards in Scotland have lay administration.

21. How far this is from the true position will be seen at once when we remember that the 84 Boards mentioned include Boards with responsibilities in outlying and island communities, 2 Boards which are Dental Boards and have no hospitals, 2 Boards of Special Hospitals which have Physician Superintendents and 24 Boards of Mental Hospitals and Mentally Defective Institutions which also have Physician Superintendents.

22. A much better way to appreciate the overall position in the Scottish Hospitals is to consider the method of administration in relation to the number of beds administered. This is done in the table in Appendix C which shows that up to the present, nearly all hospitals in Scotland of 250 beds and over are in fact medically administered and that 88 per cent. of the beds in general hospitals or 93 per cent. of all hospital beds in Scotland are medically administered.

Conclusion

23. This Memorandum serves to show that Medical Administration is a medical specialty within the profession as a whole and performing a valuable function within the National Health Service.

24. The recent report prepared for the Department of Health for Scotland on "Medical Superintendents and Medical Staff Committees" (The Henderson report) agrees with our contentions. The evidence of our Memorandum is also unreservedly supported by the Scottish Consultants and Specialists and by the World Health Organisation Expert Committee.

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25. It is our contention that the recognition of Medical Administration as a specialty in its own right is overdue and as a logical step towards that recognition we submit more adequate salary scales for whole-time Administrative Medical Superintendents and a proper career structure for Medical Administrators throughout the National Health Service.

REFERENCES

(a) Bradbeer: "A report on the Internal Administration of Hospitals" England and Wales. H.M.S.O. 1954.

(b) Central Consultants & Specialists Committee (Scotland): "Report on the Position of Medical Superintendents in the National Health Service". 1949. See also a re-affirmation of this in the Annual Report of the Central Consultants & Specialists (Scotland) 1956.

(c) W.H.O. Technical Report Series, No. 122, 1957. "Role of Hospitals in programmes of community Health Protection". Quoted also in the Chronicle of the W.H.O. June-July, 1957.

(d) Henderson: "A Report on Medical Superintendents & Medical Staff Committees". Scotland. H.M.S.O. 1957.

APPENDIX "A"

Members of Council

Sir ANDREW DAVIDSON (*Hon. President*),
Ex-Department of Health for Scotland.

Dr. S. G. M. FRANCIS (*Chairman*),
Group Medical Superintendent,
Royal Infirmary & Associated Hospitals,
Edinburgh.

Dr. C. BAINBRIDGE (*Vice-Chairman*),
Senior Administrative Medical Officer,
Eastern Regional Hospital Board,
Dundee.

Dr. P. W. R. PETRIE (*Secretary & Treasurer*),
Deputy Medical Superintendent,
Royal Infirmary & Associated Hospitals,
Edinburgh.

Dr. J. MORRISON, Group Medical Superintendent, Special Hospitals, Aberdeen.

Dr. W. MACKIE, Group Medical Superintendent, General Hospitals, County and City of Perth.

Dr. A. K. M. MACRAE, Physician Superintendent, Bangour Mental Hospital, Broxburn, West Lothian.

Dr. A. MENZIES, Medical Officer, Department of Health for Scotland.

Dr. A. D. BRIGGS, Medical Superintendent, Stobhill Hospital, Glasgow.

Dr. W. A. MURRAY, Physician Superintendent, East Fortune Hospital.

Dr. F. D. BEDDARD, Senior Administrative Medical Officer, North-Eastern Regional Hospital Board, Aberdeen.

Dr. J. K. ANDERSON, Medical Superintendent, Royal Infirmary, Glasgow.

Dr. G. H. SCOULAR, Group Medical Superintendent, North and South Ayrshire Boards of Management.

Dr. J. M. CUTHBERT, Medical Superintendent, Angus, Stracathro and Brechin Boards of Management.

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APPENDIX "B"

WORLD HEALTH ORGANISATION TECHNICAL REPORT SERIES No. 122

ROLE OF HOSPITALS IN PROGRAMMES OF COMMUNITY HEALTH PROTECTION

7. Administration and Organisation

page 23

7.—(1) *The Hospital Administrator and hospital staff*

The Committee noted that in a certain number of countries hospital management is carried out by non-medical administrators, usually trained at commercial or business schools. In other countries, hospitals are administered by physicians with special administrative experience, and it was mentioned that at least in one country a public health degree was necessary in order to become director of a general hospital. The Committee was of the opinion that, for the overall administration of a hospital, a physician was preferable to a layman. Among the arguments advanced in support of this contention was that a medically qualified administrator would tend to enjoy greater confidence and respect and therefore closer co-operation from all the professional staff who have direct contact with the members of the community seeking help and guidance. He would also better understand the needs and problems of a hospital service and would, in consequence, have the best chance of arriving at satisfactory decisions.

It was, however, recognised that a large part of the day-to-day administration of a hospital is concerned with what were called "house-keeping" duties which are essential for the overall management of any establishment catering for human wants. The Committee thought that this aspect was often unduly stressed, important though it admittedly is. A medically-qualified hospital administrator could nevertheless be assisted by a fully-trained lay hospital administrative assistant who could be responsible for these duties. On the other hand, an administrative committee could be organised to assist the hospital administrator to discharge these duties. It was recommended that a senior nurse should always be a member of such a committee.

It was agreed that a physician-administrator of a large hospital should be employed on a full-time basis, preferably without clinical responsibilities, and he should be adequately trained in hospital administrative techniques. It was also emphasised that a careful evaluation of candidates for hospital administration training should always be made to ensure that medical trainees who have a "flair" for administrative and public health work are selected.

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APPENDIX C

HOSPITAL BEDS IN SCOTLAND AND THEIR METHOD OF SUPERINTENDENCE IN RELATION TO THE SIZE AND TYPE OF HOSPITAL

The figures used here are taken from the 1957 edition of the Hospitals Year Book

Size and Type of Hospital		With full-time Administrative Medical Superintendents		With Surgeon and Pbysician Superintendents		With part-time Medical Superintendents		Others	
		No. of Hospital	Total beds	No. of Hospital	Total beds	No. of Hospital	Total beds	No. of Hospital	Total beds
Over 500 beds	General	16	12,836	3	1,899	—	—	1	796
	Mental	—	—	20	20,483	—	—	—	—
250 but under 500 beds	General	17	5,467	1	362	—	—	—	—
	Mental	—	—	9	3,560	—	—	—	—
100 but under 250 beds	General	42	6,161	4	798	7	1,003	10	1,637
	Mental	—	—	12	1,985	—	—	—	—
50 but under 100 beds	General	35	2,446	7	453	9	575	13	894
	Mental	—	—	1	71	—	—	—	—
Under 50 beds	General	84	2,188	3	106	33	731	61	1,410
	Mental	—	—	6	116	—	—	—	—
TOTALS	General	194	29,098	18	3,618	49	2,309	85	4,737
	Mental	—	—	48	26,215	—	—	—	—

Thus:—(i) Of 65,977 hospital beds in Scotland under the National Health Service, only 4,737 are without Medical Superintendence, i.e., 7 per cent. of the total.

(ii) Of 39,762 bospital beds in Scotland exclusive of the Mental Health beds, 29,098 are administered by whole-time Administrative Medical Superintendents, i.e., 73 per cent., and of tbe remainder a further 15 per cent. is medically administered either by part-time Medical Superintendents or Physician Superintendents.

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Examination of Witnesses

DR. S. G. M. FRANCIS, *Chairman of the Association*
DR. C. BAINBRIDGE, *Vice-Chairman*
DR. F. D. BEDDARD
DR. W. MACKIE
DR. P. W. R. PETRIE, *Honorary Secretary and Treasurer*
on behalf of the Scottish Association of Medical Administrators

Called and Examined

4810. *Chairman*: Dr. Francis, as Chairman of the Scottish Association of Medical Administrators you will be acting as the principal spokesman, will you?——*Dr. Francis*: We discussed this this morning, Sir, and although I can act as spokesman if you like, I would prefer just to direct the batting order because I do not want to do all the talking.

4811. You will find questions being shot at you from any member of the Commission on these matters, but principally from Sir Hugh Watson, who has been the Chairman of the Subcommittee which has considered this particular batch of evidence. I must remind you that this is a public session, so anything which is said is liable to appear in print, at any rate in the printed evidence which we will eventually produce. You are concerned with a particular point and we intend to try and keep it to the rather narrow issue which affects administrators in particular. We may have to go a little to one side or another of that. That therefore means we do not expect to cover every point you have raised in your memorandum, but I hope you will not think that those we do not cover are necessarily either accepted or considered irrelevant, because of course we have covered much of the ground with other bodies from time to time. Equally of course, as you probably know, if we do not question you nobody else will, and so we shall question you perhaps rather firmly. You are not to take that as implying any kind of hostility.——No, Sir, we will not.

4812. Would you mind first, for the purposes of the record, describing your Association and its coverage, membership and so forth?——The Association has been in existence now for four years, and it was formed by our agreeing amongst ourselves to dissolve the Medical Superintendents' Society, Scottish branch, and reconstitute ourselves into a Scottish Association of Medical Administrators. We now embrace doctors in the Department of Health who are interested in the hospital side of the Health Service, Regional Board medical officers and administrative medical superintendents of Scottish hospitals, as well as physician superintendents such as we have in mental hospitals or in tuberculosis sanatoria.

4813. How many members have you?——The paid-up membership is about 50.

4814. And how many could there be?——Eighty-five.

4815. *Sir Hugh Watson*: What exactly do you mean by the paid-up membership?——We look upon that as the active membership of the Association, Sir. If people pay their subscriptions we reckon they are really active functioning members.

4816. So out of the possible 85, you have got 50 members who take a really active and live interest in your body?——Yes. We send our circulars to all the appropriate people in Scotland, but of course the balance of 30 largely consists of general practitioners who are acting as medical superintendents in small cottage hospitals in rural Scotland. —*Dr. Petrie*: Not all the mental hospital superintendents are paid-up members.

4817. *Chairman*: What proportion of the 85, roughly, would be in mental hospitals?——*Dr. Francis*: It would be fair to say, Sir, that we have got good representation from the Regional Boards, and the administrative medical superintendents to a man support us very strongly. As we say, not all the physician superintendents of mental hospitals are members; they have their own association which was in existence long before we

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started. The rest are I think general practitioners who cannot get away to come to our meetings.—*Dr. Petrie*: There are 24 Boards of mental hospitals and there are 22 Boards of general hospitals; there are several mixed.

4818. *Sir Hugh Watson*: We know from the papers which you have been good enough to give us that there are differing views about the way in which hospital administration should be dealt with in England and in Scotland. As you appreciate, the Commission are not concerned to enquire into the merits of these two views; for this purpose the Commission I think are prepared to accept that the one method is adopted in Scotland. They would like, to enable them to appraise the remuneration appropriate to the people who carry on that administration, to find out something about exactly what these doctors do and how in fact the hospitals are administered. In your paragraph 10 you say: "since a hospital is for the care of patients, and since the care of patients is a medical responsibility, medically trained men are best suited to administer the hospitals; in fact, that Medicine is a profession within which Medical Administration has a logical and recognised place". That is your philosophy about this matter is it?——*Dr. Francis*: Yes, Sir.

4819. Would you like to expand that and tell the Commission just why you feel that hospitals ought to be administered by doctors rather than hy lay administrators?——I would like to answer this question if I may by asking Dr. Beddard, who is an Englishman who worked in the National Health Service in England and who is now with the North Eastern region, to answer that on behalf of the Association, as he has experience of both methods of administration.

4820. In that case could I ask Dr. Beddard, do your Association agree with the summary of the duties of the office set out in paragraph 133 of the Henderson report?——*Dr. Beddard*: Yes, we do, Sir.

4821. So we can take it these really are the duties of the medical superintendent in Scotland?——Yes, I would say so.

4822. What are the relations of the medical superintendent to his Board?——It varies to some extent from Board to Board, in my experience, but generally speaking in Scotland he is at the moment considered to be the chief executive officer, that is to say, he is expected to keep an overall picture of what is going on in the hospital and to take decisions on his own responsibility on all matters affecting the patient, except matters concerned with finance. That is perhaps a generalisation, as it varies I think from Board to Board.

4823. I do not want to interrupt you, but what exactly do you mean by saying "all matters in connection with the patient", because as I understand it the medical administrator has no clinical responsibility?——I meant of course all matters concerned in the administration of the hospital which have a hearing on the patient. That would include such things as the organisation of out-patient departments, records, and catering, which one might consider was a purely lay activity. In fact the medical superintendent is expected to take a considerable interest in the catering of the hospital, because it directly affects the patient. The financial arrangements, the budgeting, do not come into his sphere except in so far as hospital medical equipment is concerned. The amount of interest the medical superintendent takes in the purely domestic affairs of the hospital, the engineering services, the domestic servioes and so on, varies to some extent and I think many of us feel that in some hospitals the medical superintendents should be able to offload some of that work on to lay administrators. I think most of them now try to do so. I think it would be true to say—although this is rather before my time—that traditionally the medical superintendent was concerned in the past much more than he is now even, with those sorts of matters.

4824. You mean he had to give directions for the stoking of the boiler, and that sort of thing?——Yes, but that is not the position now, and it certainly would not be our case that those duties should fall to the medical superintendent.

4825. Perhaps it would help if for the purposes of the record I just quote paragraph 33 of the Henderson report very shortly. In the view of the Henderson Committee the functions of the medical superintendent were as follows: (1) "He ought to be in a position to advise the Board about the most effective use of the hospital resources . . ." (2)

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"general supervision of the junior medical staff, pharmacy, and medical auxiliaries." (3) "supervision and organisation of the out-patient department." (4) "Advise on hospital planning, furnishings and equipment." (5) "Liaison with administrative officers of the Regional Hospital Board . . . " and (6) "Co-operation with the Dean of the Faculty of Medicine about the provision of teaching facilities". These are the principal functions. I suppose one of the most important of these is the supervision and organisation of the out-patient department, at least so far as the patient is concerned?——Yes, Sir, that is a major operation which has to be done. If it is once organised effectively it requires not a lot of the superintendent's time to keep the machinery in motion, but that is certainly a thing which he has done and does do. —*Dr. Francis*: I wonder, Sir, if I might come in at that point? I did ask Dr. Beddard to speak to this on our behalf because I was under the impression at that time that you were discussing the differences between Scotland and England, and as he has experience of both methods I thought he could bring out these points from his experience. If you want to know the duties of the medical superintendent, as in fact they are carried out, I would ask——

4826. I do not think we want to be drawn into a oontroversy as to which is the best way of doing the thing. I think for the present purpose the Commission is prepared to accept that a certain method is in fact used in Scotland. What we want to find out really is how in fact hospital administration in Scotland is carried out.——If we could, in addition to the paragraphs you have read out from the Henderson report, mention that there is also paragraph 7 which is of the greatest importance——

4827. Yes, if you please. " . . . he ought to be a co-ordinator of all the activities in the hospital"?——Yes, Sir, we consider that is fundamental to the good running of the hospital.

4828. Then in the next paragraph " . . . we do not think it desirable that a nedical superintendent in carrying out the functions listed above should be responsible for example for gardens, porters, maintenance staff or laundry though he may be concerned with these services from time to time as an aspect of his co-ordinating responsibility . . ."——Yes, Sir.

4829. What are the relations of the medical superintendent with the medical staff?——The relations, I think, in my experience and the experience of my colleagues, are extremely good. You have a two-way function with the staff. First of all, they have in Scotland a very well organised system of medical staff committees. The system varies from hospital to hospital depending on its size, but fundamentally it is the consultants getting together and, ambitious for the improvement of the hospital, putting up proposals for the improvement of the hospital service. These proposals come to the Board of Management, and they are discussed at that Board of Management. They have direct access to the Board, but in actual fact find it very convenient to do it through the Superintendent; so that our relations with the staff are in the form of information and help coming upwards to the Board, and then transmitting the views of the Board downwards to the staff again. There is a two-way traffic in our relations with the staff. It is a very wide relationship, because not only is there the formal business of the Board to discuss with them, but there is a great deal of day to day sorting out of problems, medico-legal problems, the question of closing wards because of infection. Any worries at all which the consultant has, he can come and discuss with the Medical Superintendent, because one of the strongest things about our position is that, having no clinical responsibilities at all but having had a good basic training before we got these jobs, we can help enormously in the day to day problems which are a little outwith their province as doctors entirely in charge of the patients. The clinician in Scotland has complete professional integrity and independence to look after his patients; the Secretary and Treasurer has complete professional integrity and independence to look after his budgeting, his Board minutes, and the general business management of the hospital—all these things which are mentioned in the Henderson Report which are not strictly speaking the Superintendent's responsibility. But the final co-ordination of all that on behalf of the patient rests with the Superintendent acting for the Board of Management. The position is very much like a ship which is going out to India and back again: when the ship is in port at Tilbury it belongs to the P. & O. Company, but when it is at sea

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it is the captain's responsibility. During the days between the meetings of the Board of Management somebody has to set the ship's course on behalf of the company, and that is what the Superintendent does. A lot of day to day decisions have to be taken; you have got to be right on your toes; you have got to know where you are going; somebody has to carry the can.

4830. Then in practice how is the day to day management of the hospital divided between the Medical Superintendent and the Secretary?——The Secretary is responsible for the minutes of the Board of Management, letters from the Board on their behalf to other outside bodies, except where they are purely medical letters. He is custodian of the funds, secretary and treasurer. In addition to that he is what we loosely describe as the business manager of the hospital; he looks after the question of contracts for provisions, and so on, and, for example, he would be responsible for the house steward's department and the works department, and everything that does not fit into the Medical Superintendent's duties. For instance, if you were ordering new sterilisers we would be involved in choosing the type of steriliser in association with the clinicians who were interested in a particular pattern; and when the final pattern had been chosen and approved by the Board the Secretary would place the contract for its provision.

4831. *Dr. Francis,* in sub-paragraph xvii on page 1040 of your memorandum you say: "The Medical superintendent is a specialist requiring sound clinical knowledge . . . the medical superintendent is the person in hospital who carries ultimate responsibility". What exactly have you in mind by that expression?——The analogy with the captain of the ship is really what I have in mind, that is exactly what the position is. The Clinician has responsibility for the actual treatment of his patient, complete independence to carry it out in any way he thinks best; the Secretary and Treasurer has his responsibilities with finance, secretarial work for the Board; but the final responsibility for things going wrong comes back to the Superintendent. We deal with all complaints, we have to rise to the occasion and cope with all emergencies. I can give you two examples of the sort of thing I mean—it might help the Commission to appreciate the position because I do not want to talk of generalities; they mean nothing to people who do not know the form in hospitals at all. But I would like, if I may, to give you, say, two examples which have happened to me, which are completely apposite I think. One was on a particular Saturday in Edinburgh when we were under extremely heavy pressure on the medical side. It was in the early part of the winter and the medical beds were very overloaded with patients; we had extra beds up in every single ward. We were very heavily stretched, and particularly short of beds for male medical cases. That day I rang up the Bed Bureau in Edinburgh and explained our difficulty; they agreed to send all medical emergencies, the males, to a hospital in West Lothian and give us a chance to recover from the large number of patients we had. That worked very well; I was quite happy about it. But unfortunately that afternoon Hearts were playing Rangers, there were two quick goals in three minutes, and we had five coronaries—three of them were in the crowd, one man was going through the turnstiles and the other was just walking about. These people were brought straight out by the police to the Edinburgh Royal Infirmary. There literally were no medical beds for them at all; extra beds were put up in the middle of all the wards. I was told about this, and I went straight over and saw them, though I had no clinical responsibilities. The doctor doing the admissions was desperate, and told me so. I then said: "Can I see the surgical bed state?" I checked the surgical ward, which had some empty beds, because it was getting ready for its take-in day on Monday, and I admitted these cases to the surgical side at Edinburgh Royal. I realised it was necessary and arranged for extra staff to be seconded to look after them, and then as we got vacancies in the medical side due to deaths over the week end, they would be transferred. Having done that I then rang up the surgeon whose beds they were and said I was very sorry about this but we had to do it, and I hoped the beds would be cleared by the Monday when his cases were coming in for operation on Tuesday. The first case died 40 minutes later; the second one died that night, the third one on Sunday, and the other two were transferred. If we had sent these cases on to

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another hospital these three would certainly have died in the ambulance, and we might have lost the lot. The two points about that were that a decision was taken by the senior administrative officer of the hospital which definitely saved lives, and secondly that the senior clinical staff accepted that position; they would have thought me a very bad Superintendent if I had not done it. That is a very good state of affairs, that a surgeon will agree to such a procedure.

That is one example. Another example was in the middle of the night, about 1.30 a.m. We had a failure in the heating services, and we got a great deal of hot water and steam being pushed through the cold water services. There was a flood, and of course it happened in one of the surgical wards. There was a tremendous flood with steam and hot water pouring all over the place, and the ceiling came down. I came straight across got hold of the duty room and found out which surgical ward was getting empty for its next day's admissions, rang up that surgeon, said we would have to bring him into commission straight away, and use his beds for the admissions that were really due for another ward. We actually coped with this, where a ward was completely flooded out, without even stopping the admission of surgical emergencies—and when I say that, the surgical emergencies in any one night in Edinburgh Royal amount to about 16 to 20, and it meant we really had to get moving. These are two examples of where, quite fortuitously, immediate decisions had to be taken; and they had got to be taken by somebody.

4832. *Chairman*: What I am not quite clear about is whether those decisions would have been taken in exactly the same way, just as quickly, just as efficiently and just as much accepted by the surgeons in charge of the surgical wards, if for instance, it had not been a clinically qualified man who did it?—— *Dr. Petrie*: I think the examples Dr. Francis has chosen are very good ones, and I do not think the medical staff would accept these decisions so well if it had not been a clinically qualified man. But there are other cases where it is a matter of judgment requiring knowledge of infectious disease, where a case of dysentery occurs in a ward and one has to take a decision as to whether this is something which has come in and has not infected the rest of the ward, or whether one must close the ward. That decision too must be taken quickly, and I am quite sure that it is better taken by a medical man.

4833. *Sir Hugh Watson*: You mentioned these two appropriate instances, Dr. Francis, as typical of what you regard as the ultimate responsibility of the hospital administrator. It is in that sense, in the sense of being responsible for making emergency arrangements and that sort of thing, that you regard you and your colleagues as having the ultimate responsibility?—*Dr. Francis*: Yes.

4834. We have heard a great deal from other branches of your profession about the training and, as it is put in the higher spheres, the very severe discipline which they have to undergo to qualify for their particular branches of your profession. As I understand it from your paragraph 18 (iv), to commence a career as a hospital administrator, according to the Scottish practice all that one requires—and I am not in any way belittling the qualification—is a degree as Bachelor of Medicine and Bachelor of Surgery with possibly a D.P.H. qualification to follow, is that right?——Yes, Sir.

4835. In your paragraph xvii which I have read already, you describe the medical superintendent as a specialist; are you describing him as a specialist in the sense that a consultant is a specialist, for instance?——A consultant, Sir, has naturally to have his Fellowship or his Membership, and he has a higher qualification in either medicine or surgery, or whatever his particular branch of medicine is, and I agree that on that basis we would not be in the same category, from the point of view of having passed examinations, as a surgeon or a physician. But I think that the training for Medical Superintendent, if he is going to be any good at all, is just as long and just as difficult to accomplish, and needs certain qualities which I think are worth appreciating. I think you do not want men to go in for medical administration when they are too young, I think they must have had a very good clinical training indeed so that they are able to understand the problems of a hospital. We do not want boys of 25 going in for this sort of thing, and we do not want men who have not got a natural aptitude for it, because it is a

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very difficult thing to do. It needs an awful lot of tact, it needs an awful lot of understanding and infinite patience, and a very flexible sort of mind in dealing with things which crop up. But a man who has had a good clinical training, who has been, say, registrar or senior registrar and who in his early thirties finds he has an aptitude for medical administration, I think he should then be seconded. There are all sorts of proposals in the Henderson Report for the training of Medical Superintendents, and in fact I actually take part in this training and Dr. Petrie and Dr. Mackie take part as well; St. Andrews University in Edinburgh give lectures on the subject. But I think a man should embark on a provisional training as potential Superintendent or Administrator in a Regional Board, and then if he shows an aptitude for it and is any good at all he can move on. But the fact that we do not actually take our Fellowships or our Memberships, though many of them have them now, I do not think is a bar to considering this as a specialist profession. It really is a most difficult thing to achieve.—*Dr. Bainbridge*: I think, Sir, the problem is that there is no examination, no qualification or degree which is really applicable to medical administration. I think we have really got to try and compensate for that lack of a specific qualification by the length and breadth of the experience which a Medical Administrator has before he takes his Superintendentship or a post in a Regional Board. Apart from hospital work, a person who is undertaking medical administration should have some experience and knowledge of conditions outside the hospital. Really if possible a spell in general practice is often of considerable advantage to a person dealing with medical administration, because then he knows what are the home circumstances and conditions from which patients come and may be returned to. I think the nearest qualification we have is the D.P.H., which admittedly on calibre does not compare with the Fellowship or Membership of the Royal College of Physicians or Surgeons, but it really is the only degree which does embrace an element of administration.—*Dr. Francis*: In the United States and Canada of course there are training courses for medical administration.

4836. In Canada are hospitals largely administered by medical men?——Yes, Sir. I think the position here is that there is a curious historical and geographical distribution about medical administration. I think the best way of looking at it is that hospitals which were founded by the Church tend to have lay administration, because it may be that the lay secretary is the lineal descendant of the abbot, but in those countries where hospitals were founded by the profession they tend to have medical administrators. Hospitals in Scotland, for example, were founded after the Reformation, because at the time of the Reformation what hospitals there were just disappeared; but the hospitals in Scotland were founded after the Reformation and they have medical superintendents. And you find for instance that in Belgium and France and further south there tends to be lay administration, but in Holland there is medical administration. I do not know if it is an advantage to us that Russia has medical superintendents, but they do. The British Dominions do, and so does the United States. In the United States it is not a hundred per cent., nor is it in Canada, because they have difficulty in getting men of the required calibre, but the position is that where they can get medical men they like to have them, and in fact they have training courses in New York and in Toronto specifically for training medical administrators for these posts. An instance of where they have changed their minds is Chile; there the Church did found the hospitals but they have changed to medical administration because they found it more efficient. The position is that in the civilised world far more countries have medical superintendents than do not.

4837. *Chairman*: But most of them do not have them universally?——Holland has them universally and they are employed in the major teaching hospitals in Canada.—*Dr. Petrie*: I think Portugal has them universally, too, Sir.

4838. And usually if you are once a Medical Superintendent do you remain as such, or do you come back to having a different kind of job, a consultant, for example, with clinical responsibilities?——*Dr. Francis*: No, Sir, I look upon being Medical Superintendent of Edinburgh Royal as top of the tree; it is a wonderful job.

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4839. Yes, hut in general terms do Medical Administrators come to the top of their particular tree and then transfer, or not—not necessarily going up hut transferring to another tree?——Unless that tree was also in administration, they would not, Sir. Obviously if they had been administering a hospital for ten years they could not go back to gynaecology or anything like that. I think if they are any good, once they are in it they stay in it.—*Dr. Petrie*: They could go on to other administrative departments.

4840. But once they have lost the power to make use of their clinical training, they never get it hack, is that right? ——*Dr. Francis*: That is a curious question, Sir, if I may say so. They have not really lost it. They cannot be a good Superintendent of a hospital unless they are doctors, I am quite certain of that. —*Dr. Petrie*: I think the point is that they have widened their field, and because they have not narrowed it they are not therefore likely to go hack again to consultant practice. It is the width of knowledge that is required in medical administration rather than the narrowness required in specialisation.—*Dr. Francis*: I think the only reason they have changed from heing medical superintendent is because of the force of the financial stringency.

4841. *Sir Hugh Watson*: That leads on to the next question. In subparagraph xvii, which we have looked at already, you say: "There is considerable anxiety about the future recruitment of the right kind of doctors for medical administration". Can you tell us a little about that? You have told us that your desideratum is that you should have recruited into your service a doctor preferahly with a D.P.H. qualification who has had something like ten years of experience either in hospitals or in general practice. Can you tell us about your recruitment?——I think that the men are there, there are men of first-rate quality who are prepared to come forward, but the opportunities financially are so had just now that they are hanging back. We have had many enquiries from men who would like to take up medical administration but we feel that tbe present prospects are so poor that they simply cannot consider it. I think, Dr. Mackie, you have a little experience in recruiting deputy Superintendents? —*Dr. Mackie*: No, it is a question really of not filling the deputy's post until we know what is going to happen in the future to Medical Superintendents. I deal with a group of hospitals, Sir, rather than one individual hospital.

4842. *Mr. Gunlake*: You mentioned just now, Dr. Francis, formal educational courses in medical administration; can you say to what extent they are the rule or the exception in the civilised world? ——*Dr. Francis*: I only really know about Canada and the United States. We have started doing it in Scotland, but it is really only beginning.

4843. That is what I was going to lead up to—whether it was being considered in this country, and whether it might not ease the recruitment problem if such courses did in fact exist?——I think it would ease the recruitment problem up to a point, Sir, but there are two things about this: first of all, I still think that even though you have a good training period the man will still learn best as an apprentice. I do not think you can learn from the book, and I think it would be a great pity if a degree or fellowship were given in medical administration and the man then hecame a Medical Administrator just because he got through his examinations. It is a little wider than that. The second part of the prohlem is that I think you will not get good men to come forward unless they are going to get a reasonable chance of supporting a proper standard of living and competing with their other professional friends.

4844. *Sir David Hughes Parry*: I take it that only those who are medically qualified are allowed to join the courses which you mention?——Yes, Sir.

4845. *Sir Hugh Watson*: You feel that at the moment the remuneration that is open in this particular service is a definite deterrent?——Yes. The position, Sir, was that when we put in our memorandum, I and the Medical Superintendents of Glasgow Royal and Glasgow West, who look after the three top jobs in Scotland, with the biggest responsihility and naturally the biggest salaries, at that time were paid £1,000 a year less than an ordinary consultant of whom I was administratively in charge. The disparity is a little less now hecause we had an increase of about 5 per cent. But there is no inducement at all to take on the very wide and worrying work which being Superintendent of a big hospital

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entails, when in fact all your colleagues are getting £1,000 a year more than you are—and that is a straightforward consultant's job without merit award. It is pretty disheartening.

4846. Let us examine this question of remuneration, then, Dr. Francis. The remuneration of your particular branch up till now is regulated by Whitley B, is that right?——Yes.

4847. And the scale of remuneration for Medical Superintendents in Scotland is set out in Appendix B of the Henderson report on page 24?——Yes, Sir.

4848. That table discloses that the Medical Superintendents are divided into six grades, I think that is right?——Yes, Sir.

4849. And as you rightly say, Glasgow Royal, Glasgow West and Edinburgh Royal are in the top grade.——Yes.

4850. The top salary which can be achieved by the Superintendent of any of these hospitals is £2,250?——Yes, Sir.

4851. Whereas the salary of a consultant without merit award at that time was £3,100?——Actually, Sir, if I could just interpolate there, just so that we are honest about it, at the time we put in our memorandum the consultants had had their 5 per cent. increase to £3,250—you could check the dates to see if I am right, but I am certain I am—and we were actually £1,000 a year behind them at that time. But it is a small point when you are talking of £850 or £1,000.

4852. These scales of course were the result of negotiations in Whitley B and no doubt those representing you pressed from the Staff side the arguments as far as they could for increased remuneration?——Yes, Sir.

4853. And this was the most that you could get? The Henderson report in its recommendation 6 recommended that the salaries of Medical Superintendents of hospitals should be increased so that the amounts paid to the posts of greatest responsibility compare broadly with the salaries paid to consultants?——Yes, Sir.

4854. The amounts paid to the post of greatest responsibility—I suppose these are the three to which you refer?——Yes, Sir.

4855. I do not know what "compare broadly with the salaries paid to consultants" means.——I wonder, Sir, if I could put this into perspective a little? You mentioned Whitley. The position about Medical Superintendents is that in Scotland—and I am only talking about Scotland, because that is all I know about in this particular connection—the British Medical Association and the consultants and specialists and the profession generally have always supported us very strongly, and have always supported the idea that we should get paid a reasonable salary in comparison with our professional friends. About eight years ago—it might be seven, I am not just certain, but I think it was eight years ago—this was discussed with the Department of Health, and the recommendations of the B.M.A. and everybody else associated with the staff side were that we should be paid roughly the same as the consultants were getting at that time. The consultants at that time, speaking from memory, were getting £2,750, and the B.M.A. on our behalf asked for £2,800, to give them room for manœuvre with a view to coming down to about roughly the same figure.

4856. *Chairman*: This was before the 1954 settlement?——Yes, Sir. The position has not altered at all in Scotland. This claim was not recognised, we just did not get it. Then there was the Guillebaud report—there was first of all a report of March 1951, which the Secretary of State decided on advice not to publish. Then Guillebaud made his report and he said he thought there was a case for the Superintendents in Scotland being paid better salaries than they were getting. Nothing happened about that, and finally the Henderson report was published, and you have seen the recommendations. Fundamentally the position is that the recommendation as regards salaries in the Henderson report simply confirms what the B.M.A., the consultants and ourselves have always said in Scotland right from the beginning.

4857. *Sir Hugh Watson*: Can you give me the Guillebaud reference, Dr. Francis?——No, Sir, not offhand. I am talking from memory, but I think he makes a reference to recruitment.

4858. At all events, so far as the question of remuneration is concerned your point is that there have been these various recommendations, and arguments have been put forward in Whitley B, but this is the highest that your branch of the profession have so far been able to achieve?——Yes, Sir.

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4859. I have just been given the reference to the passage in Guillebaud; it is paragraph 414: "We have had a considerable amount of evidence . . . from Scottish witnesses . . . indicating that it is becoming increasingly difficult to recruit men of the right calibre . . . and if it is found that the salaries of medical superintendents are inadequate to maintain proper recruitment they should be revised". Guillebaud of course was enquiring into the cost of the National Health Service as he found it, so this observation by Guillebaud is what my learned friend Sir David Hughes Parry would call obiter. But Guillebaud made the point.——Yes, he did, and our point is that the position is just the same as it was eight years ago.

4860. *Chairman*: And is it affecting recruitment?——Yes, I think so.

4861. Are you actually short of possible candidates to follow any of you?——Yes.

4862. *Sir Hugh Watson*: When the Commission is considering this question of recruitment, they want to consider it from two aspects: first, the question of quantity, and secondly the question of quality. How do you find the position in regard to both these aspects of the matter, both quantity and quality? ——You mean as regards recruits?

4863. Yes, as regards recruits. Supposing you have a vacancy—I suppose you would start in your service by being a deputy Superintendent?——Yes, Sir.

4864. Supposing you want a deputy Superintendent for the Royal Infirmary —you advertise, do you?——Perhaps Dr. Bainbridge should answer this.—*Dr. Bainbridge*: In the Eastern region in Scotland we have had a series of advertisements for deputy Medical Superintendents. In Dundee in the General Hospital we have a Group Medical Superintendent who is responsible for the two teaching hospitals and certain ancillary hospitals, and he is supported by a deputy Group Superintendent. When I went there about three years ago, we lost the deputy Medical Superintendent, who went to one of the English Regional Hospital Boards. We advertised after that and we got one good person, a man who had a higher qualification in surgery. He was doing casualty surgery work in Newcastle region, he was interested in administration and he came to us. He was with us for only a year when he went to the Northern Ireland Regional Hospital Board as an assistant medical officer. Within a year of being there he was appointed as a deputy with one of the Metropolitan Boards. Subsequently, as a result of two advertisements, we appointed a further person who had been a junior clinician in one of the Glasgow hospitals; he had been acting as deputy Superintendent under the good auspices of the Medical Superintendent in that particular hospital, and he is with us at the moment. It is quite apparent that there are people who are interested in administration, but there are very few coming forward. But there are some of very good calibre. I would quote certainly this person who moved from us to Northern Ireland and then to the Metropolitan Board. He is a person with an F.R.C.S., and with war experience, a man of probably about 40 years of age—I forget his age at the moment —and certainly of good calibre. But I think it should be realised that the only promotion prospects for Medical Superintendents are within the Regional Hospital Boards, and of course these are limited. There are only 20 such senior posts throughout the whole of Great Britain, so there are very few for them to go to. Certainly in Scotland it does appear to me that if we appoint a person as a deputy Superintendent we probably lose him to south of the Border or to Northern Ireland.

4865. That leads me on to another point. The Henderson Committee made certain recommendations with a view to broadening the case of your service and making it what they called a career grade. You of course have seen the Department of Health memorandum No. 58/45. I do not propose to go into it in detail, but that does put forward a scheme for an alteration and a broadening of the service. That would give you a wider field, would it not?——Yes, I think this will help. This of course has just recently been published; it has not been in front of our Association yet and we have not really had a chance to discuss this in detail, but I think this closer integration will prove beneficial.

4866. The thing is only dated 3rd June, so it is very recent.—*Dr. Francis*: We have not had the opportunity of discussing it with our Association, Sir, so anything we say on it would be entirely our personal view rather than that of our friends.

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4867. I do not think the Commission really are concerned to go into whether it is a good thing or a bad thing, but it does open up a possibility of a wider field for persons with medical qualifications who are interested in hospital management?——There is one point I would like to make on this, Sir, if I might, and that is that it would appear that their idea is that having been Superintendent of a hospital you then seek your promotion up through the Regional Board. In Scotland there are only five Regional Boards, there are 14 in England, and there are a large number of Superintendents. Our feeling is that being a Superintendent of a general hospital, a big teaching hospital, is a worthwhile business in itself, not a means of promotion to somewhere else, that it is in fact the top of the tree. While this co-ordination of both Superintendents and Regional Boards into one service is a good thing in general, I do not think it is going to help the Superintendents very much if they have simply got to get jobs away from their own hospitals, which they have learnt to administer very well. There is a different type of mind needed to do the day to day administration, to take the quick and difficult decisions in a hospital, compared with work in a Regional Board.—*Dr. Bainbridge*: Perhaps I misled you slightly in my previous answer, and if I may clarify it, I was not implying that the Medical Superintendent should automatically seek promotion in a Regional Board appointment. When I said there were only 20 senior posts higher up for which they could apply, I really meant that the financial structure was such that an entrant, looking at the financial prospects of such an appointment, would see this and realise that that in all probability would be as high as he could go. There are so very few posts ahead, and the present salary structure really is a deterrent to a young person entering medical administration.

4868. I do not want to pursue this matter very much further, but what this memorandum says as its concluding point on the principles of reorganisation is: "The requisite status and influence of these medical posts will demand ability and personality in the holders: the calibre of the officers obtained will, in turn, depend upon the scope which the posts offer for exercising these qualities". What you are saying just now is that when you become a Superintendent you have got as high as you can, you are really fulfilling your function and you feel you are doing a worthwhile job?——*Dr. Francis*: Yes, indeed, it is a very fine job.

4869. But the point about what is in this memorandum is that it is going to create the opportunity for people who are minded to go in for hospital administration, and have the ability and personality, to enter the service by means of a variety of routes. Thus you might get people coming in in the lower grades who would not be induced to come in at the moment?——Yes, Sir.

4870. Dr. Francis, let us go back to the Henderson Report. His report was that the amounts paid to the posts of greatest responsibility in medical administration should compare broadly with the salaries of consultants. What do you understand that phrase to mean—"should compare broadly"?——*Dr. Francis*: That is page 1040 of our memorandum to you, Sir, where entirely in the spirit of the Henderson Report we drew up what we thought fair proposals.

4871. I would like to know very much what you understand by the expression "compare broadly". We have been faced in another connection with the famous document you have no doubt read. In all his reports Spens enjoined those who came after him to have direct regard to the cost of living and the remuneration in other professions. What is the difference between having direct regard and comparing broadly?——*Dr. Beddard*: The answer of course is that Dr. Francis did not write the words.

4872. I know who wrote the words. ——But I think the interpretation, certainly that I put on it when I read it, was that the salary should, as it were, bring the holder into the same sort of income bracket as the consultant. I think that at the moment all of us in medical administration both at Regional Boards and as Medical Superintendents of hospitals, feel we are one of the specialist staff. This point has already been made. Our speciality is administration. It means we have got to know the Acts and the Regulations to put it at its widest; we have to know how to present things to our Boards, we have to have all sorts of background knowledge,

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the same way as the specialist has to have his background knowledge. We feel we are meeting on equal terms the specialists in different fields of medicine; we meet them and work with them, and this applies to the Regional Board medical staff as well as the Superintendents. We are in a rather lower income bracket and we felt the Henderson Report recognised the fact that the senior medical administrators in the Service were on comparable terms and status—and in this world of today that means salary—with the specialists in the hospitals.

4873. Do you consider whether the sort of people that the memorandum 58/45 contemplates will be properly remunerated under the scale—"Headquarters Medical Staff of Regional Hospital Boards" which was set out as Appendix P to the factual memorandum prepared by the Ministry? Do you have this document?——No, Sir.

4874. *Chairman*: You have seen it? ——It is the Ministry's factual memorandum put out last June, and is chock full of unchallenged facts about the whole problem of medical remuneration. —*Dr. Francis*: I do not know if that has been circulated in Scotland, Sir. I have not seen it.

4875. *Sir Hugh Watson*: I do not want to appear to press you on this. Like you, I have not had the chance to discuss the Department of Health's memorandum with my colleagues and I find it very difficult to swallow, to put it crudely, the conception that even with his experience and his knowledge of Acts of Parliament, as Dr. Beddard put it, a Medical Superintendent can be compared with a consultant from the point of view of his attainments and his ability and the discipline through which he has gone. I cannot help feeling that that is why Whitley B has not been able to award any higher remuneration than they have done up to date; and I think it would help the Commission very much, Doctor, if you could tell us some reasons why it should be different. I do not know what Henderson meant when he said "compare broadly with the salaries paid to consultants".——If I could answer that in two parts, on the question of the differences in the training, there is no way of learning to be a Medical Superintendent at the present time apart from learning it as an apprentice, and it would be a little hard to penalise us just because there is not a qualification we could take. The spirit is willing but there just is not the opportunity. I am quite convinced that the type of training and personality and the sort of work a Superintendent has to do is comparable without any doubt with the sort of work a consultant does, as regards the wellbeing of the community. It is an exacting job with a great deal of hard work and certain qualities.

I think when the Henderson Report said "posts of greatest responsibility among the Superintendents should be broadly comparable" we took that as being comparable to the basic consultant scale, rising to £3,250. We scaled things down from that so that the three top jobs in medical administration went up to just the present consultant's salary and the rest tapered down. We were not unrealistic enough to think the Superintendent of a small hospital should get the same as a consultant, but we thought the three top jobs should get a little less and the others scaled down as on page 1040 of our memorandum. It was a genuine attempt to interpret this in the spirit of the Henderson Report, which I would like to emphasise is exactly what has been said all along in Scotland, right from the start. It is a unanimous feeling of our own professional colleagues, both consultants and general practitioners, and of the B.M.A., that our top jobs ought to be paid at a rate roughly comparable to the consultant.

4876. Dr. Francis, you are aware that the proposals set out on page 1040 represent an increase of about 38 per cent. for the four highest groups and 33 per cent. for the two lowest groups? ——Yes, Sir.

4877. Whereas what the B.M.A. are asking for is 29 per cent. on the remuneration existing before the 5 per cent. interim award was put into operation.——The position is very different from our point of view. It is not a cost of living increase based on the drop in value of the pound in the last so many years; it is to try to put right something we feel should have been put right eight years ago.

4878. Please do not imagine the Commission are prepared to agree to a request based purely on the cost of living.

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on my salary to give the sort of hospitality that I have received at other hospitals. At a place like Edinburgh Royal you have scores of people dropping in and entertainment costs can be very heavy indeed.—*Dr. Beddard*: This also applies of course at Regional Boards where one has a lot of visitors and one wants to entertain; I take quite a lot home. But I do not think any of us would make a tremendous point about it. At the same time we get invited out to lunch when there is a Board meeting, and special visits, and we put one against the other. But it does occur and my wife makes certain references to the house-keeping budget and so on. But I would not like you to think that we take it at all seriously.—*Dr. Francis*: We would not make a serious issue of it if we were reasonably paid, but we are not.

4898. *Mr. Gunlake*: What would you say this expense amounts to?——I have cut it down. One year we had thirteen sets of people come to stay.

4899. Let me put it another way. In your sub-paragraph xxi you say the Medical Superintendent should have an entertainment allowance. It would help if you could suggest what kind of allowance you had in mind.——In the old days of course they did get this in teaching hospitals. Sometimes there was an actual allowance and sometimes they simply said—send the bill to us.

4900. *Chairman*: It varies from place to place?——Yes, a place like the Royal does attract people in particularly large numbers. I would not like to mislead you on this. I should think it should be something between £25 and £50 a year. If one were reasonably paid one would not raise the point at all but would be prepared to take it in one's stride.

4901. *Mr. Gunlake*: In sub-paragraph xx you say, Dr. Francis, that the Association should be included in the machinery for discussions and negotiations. We briefly talked of Whitley B. Does that mean the Association has made an attempt to be involved in this machinery and has failed and, if so, can you tell us why it failed?——When it all started way back we had not a Medical Superintendents Society and then we formed ourselves into an Association. We hope that in the future we will be recognised as a negotiating body.

4902. Have you made any attempt to get recognition?——Yes, Sir.

4903. And so far it has not necessarily been refused?——No, Sir.

4904. *Chairman*: You said you were formerly the Scottish Branch of the United Kingdom Association. What are your relations with the rest of the United Kingdom now? You are not affiliated in any way?——No, we simply committed hari kari and formed an entirely new Association with a much bigger and more active membership. It is really alive now. Our relationship with our colleagues in England is one of friendly alliance and association, but nothing more formal. Their Chairman and Secretary usually attend our annual general meetings and we attend theirs but we are not linked up in any way.

4905. *Mr. Gunlake*: To quote the famous words, your relations with foreign powers continue to be friendly? ——Very friendly, yes.

4906. *Chairman*: We have covered all the points you wish to refer to, Dr. Francis?——Yes, Sir.

4907. *Chairman*: I think we have understood your views. Thank you very much.——Thank you very much indeed, Sir.

(*The witnesses withdrew*)

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EVIDENCE SUBMITTED BY THE MEDICAL SUPERINTENDENTS' SOCIETY TO THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

General

1. The Medical Superintendents' Society represents the interests of medical superintendents of hospitals, and their deputies, in England and Wales. All mental hospitals, and mental deficiency hospitals, have as their chief officer, medical superintendents who have statutory powers. The mental and mental deficiency hospitals account for approximately 45 per cent. of the hospital beds of the country. Many of the former municipal hospitals, both general and special, still have medical superintendents, so that there are over 50 per cent. of the hospital beds of the country for which medical superintendents are responsible. Yet the very existence of the medical superintendent or physician superintendent has been tacitly ignored by the Ministry of Health.

2. Most medical superintendents are consultants in their various specialties and remunerated as such. They are given a variety of titles of which the most common are physician superintendent, surgeon superintendent or medical director. Some have been graded as senior hospital medical officers. The Society knows of only two medical superintendents in England and Wales whose work is wholly administrative; all others combine clinical and administrative duties. The position in Scotland is somewhat different in as much as the chief officer in all types of hospital in Scotland is a medical superintendent who, however, does not usually have clinical duties, but the Scottish Association of Medical Administrators will be dealing with their own problems.

3. The duties and responsibilities of the medical superintendents have been set out in considerable detail in the Report of the Committee on the Internal Administration of Hospitals (Bradbeer Committee, 1954) and we would like to draw the attention of the Royal Commission to Paragraph 61 et seq. and Appendix B, subsection ii and iii of that report.

History of the Society

4. The Society was founded in 1886. Its members were the medical superintendents of the Metropolitan Poor Law Infirmaries. All the minutes of its meetings since its foundation have been preserved. Its interests were chiefly clinical in those days, but as the various administrative problems of large hospitals increased so they assumed greater importance in the Society's proceedings. Subsequently, medical superintendents of provincial poor law infirmaries were admitted to membership, and still later medical superintendents of mental hospitals and other special hospitals. In 1935, deputy medical superintendents were admitted for the first time. There are 250 ordinary and 97 honorary members in the Society. The Society is divided into Branches arranged on a geographical basis, so that members may more easily meet to discuss mutual interests and problems. In 1954 the Scottish Branch separated from the parent body and formed the basis of the recently formed Scottish Association of Medical Administrators. The Society has at different times in its history made representations to governmental bodies on various topics, including the Royal Commission on the Poor Laws and Relief of Distress in 1906. It has given evidence to the Bradbeer and other committees since 1948.

5. The Society submits with this document copies of its Constitution and List of Members for 1956-57. We would call attention to its Objects in Paragraph 3, particularly 3 (*a*) which states: "For mutual help in administrative problems, and in the promotion and maintenance of the highest possible efficiency of Hospitals." We are the only body specifically concerned with the interests of medical superintendents and their deputies.

Comments on various points raised by the Royal Commission in its circulated Memorandum.

6. Question (ii).

The quality of British qualified doctors is quite satisfactory. We are unable to comment upon the quantity in general, but have found that there is a consider-

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able shortage of juniors offering themselves for service in certain specialties such as psychiatry and neuro-surgery, with the resulting failure to attract applicants of suitable quality. We believe that this is due to the poor prospects of promotion in such specialties. This is particularly true in the provinces.

7. Question (v).

The prospects of a newly qualified doctor are vitiated by the rigidity of the Health Service. A man cannot readily transfer from one specialty to another, nor into general practice. In general practice too he cannot readily transfer from one part of the country to another.

8. Question (vi).

In certain specialties there is a bottle-neck in promotion prospects, in consequence of which (as referred to under (ii)), there is a tendency to take up general medicine and obstetrics from which an easier transfer to general practice is possible. In time, this creates further congestion in these latter specialties.

9. Question (vii) (c and d). *Relative advantages and disadvantages of whole-time and part-time consultant practice.*

(a) *Advantages of whole-time consultant service.*

1. The divorce of financial consideration from clinical work.

2. The consultant is able to devote himself exclusively to his hospital work and domiciliary consultations. He is not exposed to a conflict in loyalties between hospital and private practice.

3. The working conditions of the whole-time and part-time consultant are essentially the same, as far as his hospital work is concerned, and there is no difference in security. The Society is definitely not in favour of a fully whole-time service, but believes that there is a place for both whole-time and part-time consultants. Indeed, a proper balance between the two gives a sounder and more healthy service.

4. In certain specialties in some areas it would not be possible to get suitable men other than whole-time consultants, as there would be little or no opportunities for private work, e.g. radio-therapy, thoracic and neuro-surgery.

(b) *Disadvantages of whole-time consultant service.*

1. The whole-time consultant must make eight free domiciliary visits each quarter before he becomes eligible for any fees.

2. He is not allowed expenses for income tax purposes which his part-time colleague is allowed, such as the cost of books and journals, subscriptions to professional societies, and the renewal of instruments and other equipment, etc.

3. His earnings are limited to his salary, plus certain specified fees, while the part-time consultant has no limit to his earnings outside the Hospital Service. The latter, if holding the maximum number of sessions, nine per week, is paid for nine and a half sessions work. His pension is also therefore relatively higher as far as his hospital work is concerned. Many whole-timers in consequence are electing to go on maximum part-time service because of the financial advantages. It might be as well at this point to refer to the Report of the Royal Commission on the Taxation of Profits and Income. In their report, in paragraph 129, the Royal Commission states that the general impression is that the rule governing the deduction of expenses in respect of offices or employment under Schedule E is too narrow. This is of course Rule 9. They recommended a re-wording of Rule 9 on less restricted lines allowing the deduction of all expenses reasonably incurred for the appropriate performance of the duties of the office or employment. They also made recommendations with regard to personal expenses, including such things as entertainment allowance, benefits in kind, and reimbursed expense.

4. It may be argued that the whole-time consultant, if working in the hospital only, may develop a parochial outlook, but this can equally apply to the part-time consultant, and is dependent upon the personality of the individual. It might equally well be argued that the part-time consultant, if attached to several hospitals, may have very little interest in the community life of any of the individual hospitals

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10. Question (vii).

(f) *Senior Hospital Medical Officers.*

No grade has given rise to more frustration than this one, and its future should be given careful consideration. It was originally designed for those who in 1948 were not considered worthy of consultant status, and was intended to he a grade which would die out. In spite of this, new appointments continue to be made to this grade in certain specialties; in fact the grade is heing added to the establishments of certain hospitals. The Society disapproves of the grade as it is at present constituted, and considers that while it still exists individuals in it should have their grading reviewed at regular intervals of not more than five years.

11. Question (viii).

The salary of a junior hospital officer (i.e. helow registrar grade) after registration should be raised to a level comparahle to that of a trainee assistant in general practice. The conditions during the training years (25 to 35) are very unattractive and indeed cause considerable financial hardship and much frustration.

12. Question (xv).

Merit Awards.

Many people disapprove of merit awards, the chief objection being the secrecy with which they are surrounded. It is true that there are certain advantages in this very secrecy. The criteria on which they are awarded are not known, and we consider that certain standards should he laid down. We cannot offer any satisfactory alternative to the present system, hecause some such method of rewarding specific talents and skill is desirable. It might, however, be suggested that suitable representative regional committees should be officially appointed to advise regarding such awards.

13. At present only clinicians are eligihle for merit awards.

We consider that those men who are pre-eminent in the administration of their hospital, quite apart from any clinical work they may do, should not he excluded from consideration. It is the total picture of the man's professional work in the service which should be taken into account.

14. Question (xx).

Whitley Council Machinery.

There is general dissatisfaction with the Whitley Councils.

The Guillehaud Committee Report discussed the matter in considerahle detail (paragraphs 679 to 698, and 734). They were originally set up for those in government employment, and if the employee was dissatisfied he had the alternative of other work with another employer. In the National Health Service there is no alternative employer for the doctor. This is an entirely new feature in puhlic service. We deplore the present wrangles concerning remuneration, and consider that they could he avoided in future if there was a proper system of independent arbitration at the request of either side.

15. *Remuneration of Medical Superintendents.*

The Society does not intend to express any specific views regarding the remuneration in general of consultants and other hospital medical staff, as evidence on this will be fully presented by the British Medical Association and other bodies. It is concerned with the remuneration of medical superintendents and their deputies in relation to that of exclusively clinical consultants. All mental hospitals have medical superintendents, and practically all sanatoria and special hospitals, except the very small ones. A large number of general hospitals also have medical superintendents. With the exceptions already mentioned in paragraph 2, all combine clinical duties with administration. In accordance with the Industrial Court Award of the 22nd January, 1952, if a medical superintendent is engaged for 32 hours per week in clinical duties he is paid wholly as a consultant or a senior hospital medical officer, according to his clinical grading.

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16. In addition to his clinical work, the medical superintendent has administrative responsibilities and duties, and these may be at times of greater moment and of a more demanding nature in time and mental effort even than his clinical work. If resident he is never wholly off duty unless he goes out of the building: even then he may be held responsible for things which happen in the hospital when he is absent. In other words, he is more completely whole-time than any other medical officer.

17. In most cases it is a condition of his employment that he is resident (or must live so close to the hospital that he is virtually resident), the employing authority recognising the obvious value of having a senior officer upon the premises. This condition of residence imposes many disadvantages both on the medical superintendent and his wife and family, particularly in isolated areas. Many mental, mental deficiency and special hospitals are sited away from towns. As a result of this, social contact both for the medical superintendent and his family is not easy, and he is not able to purchase a house for a permanent residence. The charges made for his accommodation would go a long way toward meeting a redemption mortgage on a house that he might occupy if non-resident. When he approaches retirement, then, in the latter years of his life, he has to begin the process of purchasing and setting up a new home.

18. His administrative responsibilities do not end with the day-to-day administration of his hospital. He is expected to attend the regular hospital committees, and he alone is expected to attend a large number of special sub-committees. He also has to interview many of the other senior, lay, and nursing officers. He is expected, too, to take part in all the social activities of the hospital, a duty which his purely clinical colleagues may well escape. This is true in all hospitals and especially true in a mental hospital, where he must take the lead in many of the recreational activities of the patients. These many demands upon his time often result in his sacrificing not only his own social activities, but the very necessary attendance at medical societies and the taking part in similar professional activities. As a consequence also, the development of his clinical work to a degree which might earn him a merit award is liable to suffer.

19. It is no wonder, therefore, that there is a steadily increasing difficulty in finding suitable candidates for the post of medical superintendent. Both the Bradbeer Report (paragraph 118) and the Guillebaud Report (paragraph 414) refer to this point. The latter Report says in paragraph 414: "It should certainly be investigated and if it is found that the salaries of medical superintendents are inadequate to maintain proper recruitment they should be revised." Already quite a number of medical superintendents, because of these disadvantages, have given up their posts and taken a purely clinical post, either in their own or other hospitals. Equally undesirable is the possibility that some men may accept the post of medical superintendent in order to achieve consultant status, with the idea that in the future they may take a purely clinical consultant appointment.

20. For all these reasons the Society argues that a medical superintendent should be given extra remuneration over and above his purely clinical colleague. Only he has his finger on the pulse of all the hospital activities, and his value to a management committee which regularly seeks his opinion on different problems is immense.

21. Both the Bradbeer Report (paragraph 72) and the Guillebaud Report (page 146), agree that "the medical administrator must be a consultant in active clinical practice." With this we agree, with the proviso that medical superintendents whose administrative duties necessarily take more than two sessions should not be penalised. Some medical superintendents, however, have been graded as senior hospital medical officers. On the merit or demerit of this clinical grading in individual cases we cannot, of course, comment, hut we do contend that, because of the many responsibilities he carries as an administrator, and because of the many disadvantages of the post he holds, a strong case can be argued in favour of giving these medical superintendents the grading of consultant in relation to his administrative duties.

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22. Members of our own profession, among others, may raise objection to the suggestions contained in the last two paragraphs. Many consultants in the hospital service in England and Wales, though not in Scotland (see the report on Medical Superintendents and Medical Staff Committees issued hy the Department of Health for Scotland in 1957), have been keenly critical of the post of medical superintendent. Guy's Hospital is a notahle exception. They would, therefore, have opposed the suggestion that the medical superintendent should receive higher remuneration than a consultant, but it should he remembered that medical superintendents do not appoint themselves. They are appointed hy employing authorities who have deemed the appointment necessary, and have heen appointed in open competition.

Prior to 1948, the competition was very keen, with many first-class applicants for the post. It is particularly frustrating to those members of the profession who were appointed as medical superintendents prior to 1948, and who were then regarded as suitahle men for the post and who have now been graded as an S.H.M.O., to find that others who were unsuccessful in their application for the same or similar posts, are now graded as consultants.

23. It may be asked why do we medical superintendents continue in our office, and why do some candidates still come forward. There are many reasons, but the chief one is that we believe that a hospital in which there is a medical superintendent will function more efficiently and more economically. Being a doctor, the medical superintendent's chief care is the welfare of the patient, and it is his constant concern that all the various departments of the hospital function efficiently to that end.

24. *Deputy Medical Superintendents.*

We do not approve the suggestion contained in the Bradheer Report (paragraph 81), that the deputy should be of R.M.O. or R.S.O. status. In this we are supported by the Central Consultants and Specialists Committee, which in its comments on the Bradbeer Report stated that the deputy medical superintendent should be a consultant. Some hospitals now-a-days have no deputy medical superintendent, a fact we deplore. We consider such an appointment is necessary, and entirely agree that his status should be that of a consultant. We contend also that in order to induce men to take on the duties of the deputy, he must be given extra remuneration, which should be not less than 80 per cent. of that given to a medical superintendent.

References :

1. Report of the Committee on the Internal Administration of Hospitals. (Bradbeer Report, 1954.)

2. Report of the Committee of Enquiry into the Cost of the National Health Service. (Guillebaud Report, 1956.)

3. Medical Superintendents' Medical Staff Committees (Scotland), 1957.

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Examination of Witnesses

DR. G. MCCOULL, *President of the Society*
DR. M. J. BROOKES, *Chairman of Council*
DR. V. COTTON-CORNWALL
DR. A. SKENE
DR. J. M. MILLOY, *Honorary Secretary*
on behalf of the Medical Superintendents' Society

Called and Examined

4908. *Chairman*: Dr. McCoull, you will be speaking mainly for the Society, will you, or will you all wish to give evidence with yourself acting as the leader?——I think that is the position, Sir, yes.

4909. It is for anyone you wish to answer any of the questions we may put to you and in your turn, of course, you will be asked questions from any member of the Commission, particularly from Sir Hugh Watson who has been Chairman of the particular sub-committee that has gone through your evidence and has marshalled the questions we propose to put to you. Would you please remember, first of all, that anything you say will be reported?——*Dr. McCoull*: Yes, Sir.

4910. We will question you fairly thoroughly on a few aspects of this very specialised subject within our whole subject because if we do not there is nobody else to do so. Do not think we are being hostile in so doing: equally do not take it we are accepting without any comments any points that we do not raise because we have gone into many of them sufficiently with other bodies. Would you start by telling us the scope and membership of the Society including perhaps a description of the different types of membership and of activity as represented, for instance, by the five of you who are here today? ——Could I just introduce the people who are here? Dr. Brookes is a consultant psychiatrist and in charge at the Shelton Hospital, near Shrewsbury; Mr. Milloy is consulting surgeon and in charge at St. Mary Abbots Hospital Kensington; Dr. Cotton-Cornwall is chest physician and is deputy superintendent at the Aintree Hospital, Liverpool and Dr. Skene is consultant physician in charge at the Walton Hospital, also Liverpool. I myself an in charge at the Prudhoe and Monkton Hospital, which is a mental deficiency hospital. We are all consultants.

4911. How many members have you? ——250 in our Society, Sir.

4912. How many could you have had if everybody eligible were what the Scots call a paid up member?——We have tried to reckon that out this morning and thought somewhere about 400, Sir. We cannot get exact figures.

4913. You are all consultants. How many of the 400 would be of consultant status?——We do not know, Sir: it must be 95 per cent. Could I say at this point that Dr. Skene has got some figures just this morning from the Ministry. We said in paragraph 1 of our memorandum that the mental and the mental deficiency hospitals account for approximately 45 per cent. of the hospital beds of the country. We said that for over 50 per cent. of the hospital beds in the country medical superintendents are responsible. We think that is modest, Sir. We were not quite certain about figures. We thought we were under-stating. Dr. Skene has some further figures.

4914. Would you like to give us those now, Dr. Skene?——*Dr. Skene*: We only have the figures in respect of eleven of the fourteen hospital regions in England, but these show that there are 368,600 beds in these eleven regions and of these 221,600 are in hospitals which are administered by medical superintendents by name or by other terms such as medical director, physician superintendent and so on, which is just a fraction over 60 per cent.

4915. Those were mental and mental deficiency hospitals?——No, Mr. Chairman, all hospitals in England and Wales with the exception of three regions—Oxford, North East Metropolitan and Birmingham—where we have not been able to get the figures.

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4916. *Sir Hugh Watson*: Yet, you say, the very existence of the medical superintendent has been tacitly ignored by the Ministry of Health. What does that mean, Dr. McCoull?——*Dr. McCoull*: It means that in regard to circulars, memoranda and other documents from the Ministry the set up is such that they come down through lay hands and very often we find that the medical superintendent as the head of the hospital is simply not named. They go direct to the lay side. Very often we do not see them.

4917. He is by-passed?——We are often.

4918. *Chairman*: You are often by-passed on subjects dealing with administration?——Yes, Sir. Could I say that there is an official publication, the Hospital Directory I think it is called, where no medical superintendent is put down at all. Quite apart from being in charge of the hospital his name just does not appear under any hospital in the country. That is published by the Ministry I am told, Sir.

4919. Have you ever brought this to the attention of the Ministry?——As a body we have not.—*Dr. Brookes*: I think we did send a communication about five years ago.

4920. What was the answer?——I cannot remember now, Sir.

4921. *Sir Hugh Watson*: Did you employ what in other circumstances is called a follow up? You did not return to the charge?——*Dr. McCoull*: No.

4922. It astonishes me because as you know the medical superintendent is recognised as a grade for remuneration.—— Are you speaking of the administrative superintendent?

4923. I am reading from the factual memorandum given to us by the Minister of Health. Will you look at page 79, Dr. McCoull? You will find medical superintendents, graded as consultants, who are normally engaged for at least 32 hours per week are remunerated as if the whole of their duties were clinical. That seems to recognise the existence of medical superintendents.——Yes, Sir.

4924. Or again in the next paragraph, even more so, the salaries of whole-time medical superintendents are related to a pointing system.——I think you have left out the important words "engaged wholly in administrative duties."

4925. I beg your pardon. My point is this: the document seems to recognise the existence of medical superintendents.—— Indeed, I think it does. It recognises here the wholly administrative medical superintendents of which we have not got a representative. They are very few indeed, Sir.

4926. But also paragraph 1, Dr. McCoull, recognises medical superintendents graded as consultants?——Yes, Sir. If you are making the point we are recognised the answer is yes, Sir.—*Dr. Skene*: May I just say that we are recognised as consultants just as all the other consultants. In this document, as we exist and have to he paid naturally I presume we are recognised for purposes of payment, but for purposes of administration in the general hospitals—I specifically say general hospitals—there is no doubt there is considerahle suhstance in what has been said by Dr. McCoull.

4927. *Chairman*: What I cannot understand is why, if you are heing by-passed on things on which you ought to he consulted or at least informed, the Society has not said so with greater force?—— *Dr. McCoull*: It is a very small body, Sir.

4928. *Chairman*: I see.——*Dr. Brookes*: We have called the attention of the Ministry on several occasions to quite a numher of instances in which we have been by-passed. We have had no replies.

4929. *Sir Hugh Watson*: Of course various bodies have expressed views about this matter. The Guillebaud Report did confirm the views of the Bradheer Committee that the medical administrator must he a consultant in active clinical practice. I think as the Chairman says this is a matter for yourselves. It is not a matter for this Royal Commission. It seems unfortunate. This Commission is concerned with remuneration you see. Could you tell us, Dr. McCoull, how many of your memhers are superintendents of mental hospitals? ——*Dr. McCoull*: Not exactly. I should have thought about 90 per cent.

4930. Of mental deficiency hospitals? ——I included mental deficiency in that 90.

4931. Of infectious diseases hospitals? ——A small proportion.

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4932. General hospitals?——Seven or eight per cent. That is round about the distribution.

4933. You mention in your memorandum that there are only two hospitals in England and Wales where there are medical superintendents whose work is wholly administrative.——Only two we know who are members of our Society. We do not know of any more.

4934. Can you tell us what proportion of the medical superintendents to whom you refer are consultants on the one hand and S.H.M.Os. on the other?——We tried to think that out this morning. The number of S.H.M.Os. is very small indeed. It cannot be more, I imagine, than a dozen in the whole country.

4935. Tell me, Dr. McCoull, would you accept the definition of the duties and responsibilities of medical superintendents as laid down in the Bradbeer Committee's Report? You have probably seen that?——Yes, I have seen it, Sir. In general I would say yes, Sir. I would say in the mental and mental deficiency hospitals there is something extra but in general I think we can accept the Bradbeer Committee's Report.—*Dr. Skene*: May I ask Sir Hugh Watson whether he is referring to Appendix B or paragraph 61 of the Report because paragraph 61 enumerates a number of duties which the Report takes to come within the content of medical administration, whereas the Appendix, of course enumerates duties laid down for a medical superintendent. It may appear there is a very fine line of difference between those two items, bnt of course medical administration is carried out in the same sort of way in hospitals which do not have an appointed medical administrator.

4936. I think that is the point. Subject to that, with that comment, Dr. Skene, you would accept the outline of the duties and responsibilities of a medical administrator as set out in paragraph 61 of the Bradbeer Report?——Yes, Sir.

4937. You point to Sections (ii) and (iii) of Appendix B as illustrating the duties which have been laid down by a certain Board for a surgeon superintendent, and a memorandum on the relationship of medical superintendents to specialists on hospital staffs?——That is so.—*Dr. Brookes*: Those duties, Sir, are in relation generally to non-teaching hospitals, to mental and mental deficiency hospitals, where the appointment of a medical administrator is specially set down in Statutory Instruments.

4938. Mental hospitals are by statute obliged to have a medical superintendent?——And mental deficiency hospitals. Statutory Instrument 419 lays down that he is the chief officer.

4939. As I said, this Commission is concerned particularly with remuneration. We are obliged for the comments you make in paragraphs 5 to 13 of your memorandum. Perhaps you will excuse my not dealing with them. We bave had evidence from a considerable number of bodies and think we know the position about them.——*Dr. Cotton-Cornwall*: Might we, Sir, say something about some of the evidence that has been given on merit awards if you are not going to ask us any questions on that matter, because we do feel some of the statements made to you about the lack of interest shown by consultants in general in the merit award system does not correspond with the facts. Naturally everybody is interested in the amount of money that he receives and the fact that meetings in the regions have not been well attended is not due to the fact that people are not interested.

4940. *Chairman*: What is it due to?——If I may be quite frank, it is due to the fact that the question of merit awards is not dealt with at those meetings. People ask questions and they do not get answers. Since that has happened on several occasions people have ceased to attend. Speaking for the Liverpool region, the attendances at the beginning were very much better than they are now. If I may speak personally I myself went to the first two meetings that were held and decided it was a complete waste of time going to any more. I think that is fairly general—that feeling is fairly general.—*Dr. Brookes*: There are other factors. Sometimes the meeting is held at a distance from one's place of work—some 30 or 40 miles away, and it is held in the afternoon. One hardly feels inclined to go to attend a meeting at that time.

4941. I think we appreciate these meetings are held in fairly widely separated places at intervals and one cannot expect a very large attendance. In the past 250 people turned up in Newcastle.——There

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have been good attendances in my area. —*Dr. McCoull*: In paragraph 13 on merit awards, we say:

"It is the total picture of the man's professional work in the service which should be taken into account."

I feel that here we should point out to you that in the system of allocating merit awards to people it is laid down that administration does not count. In other words, one's success or otherwise in running a hospital community is not taken into account at all. We think that is part of a man's total professional capacity and we think it should be taken into account. We protest very strongly against the leaving out of administration from the merit award system.

4942. You know, Dr. McCoull, other bodies have raised the question of altering the line of demarcation of merit awards, bringing in types of doctor for instance who would not now he eligihle. The Medical Research Council indeed raised that. There has been a generally expressed feeling it is best to leave the line of demarcation where it is. You knew that?——We know that this is for you to decide but we are protesting against the fact that administration does not count. They are the words that have been used. We think it is important.—*Dr. Skene*: I think we take that view because we feel that the duty of the medical administrator in the hospital service is an important one and for the good of the service. Consequently any condition of service which will make an important appointment of that sort less attractive will carry with it a handicap from the point of view of the recipient's future financial prospects and is not calculated to maintain the quality of the service in which we are interested.

4943. You are making the same sort of point at a different sphere to the one which has heen made, for instance, by the Medical Research Council?—— Precisely, Mr. Chairman.

4944. *Sir Hugh Watson*: There is this difference, Dr. Skene, if I may act as your advocate for the moment, that the people about whom you are talking are already consultants?——That is so.

4945. It has heen expressed to the Commission that people who do no clinical work at all ought to be considered for merit awards. The Commission have so far not heen impressed hy that argument. I am not saying they have decided anything, but once you get outside the realm of clinical medicine for which merit awards were primarily intended, you are in a very difficult and wide area: hut your point is perhaps narrower—with respect, Mr. Chairman—because you are a consultant to begin with.——The point I am making, Mr. Chairman, is that the physician superintendent is a handicapped consultant in relation to his fellow consultants because there is a limit to that which even the most conscientious person can put into 24 hours and if he is undertaking clinical duties for nine-elevenths of his time he is expected to carry out clinical duties for nine-elevenths of his time. Bearing in mind the Ministry three years ago stated that a particular consultant's task may be done in whole time or in nine sessions, at the option of the consultant, then obviously the man who is doing a nine session consultant post plus all his administration is extremely handicapped in undertaking any research work in which he may be interested as compared with the pure clinician. Consequently it is unjust for him not to he considered for a merit award.

4946. *Chairman*: Dr. Skene, paragraph 1 of Appendix F of the factual memorandum to which Sir Hugh referred earlier, says that medical superintendents graded as consultants who are engaged at least 32 hours a week in clinical work are remunerated as if the whole of their duties were clinical. Would that also apply for merit award purposes, to your knowledge?——I do not know: I presume it would.—*Dr. McCoull*: Yes.

4947. So that anybody who is engaged for 32 hours a week on clinical duties as a medical superintendent is eligihle for a merit award?——*Dr. Skene*: Yes.

4948. To the full extent, and presumably if engaged for, say, 20 hours instead of 32, is eligihle for the appropriate proportion of the award?——*Dr. Cotton-Cornwall*: There are people who are medical superintendents who have merit awards. We would not like to give the impression there are not any. The argument is it is more difficult for a medical administrator being either physician superintendent or deputy to obtain a merit award because he has not got the same amount of time to give to clinical research and writing and reading of

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papers that the pure clinician has. I think that is the point I am trying to bring out.

4949. I think the Commission has got the point. I do not know to what extent they are convinced about its validity. We may need to ascertain more on that particular point from Lord Moran. I do not think that point has been put to us in that way before, that medical superintendents alone have insufficient time to do research work to keep to the level of other consultants. That is your point? —*Dr. McCoull*: They have not as much time.—*Dr. Skene*: May I put it this way? In the time the consultant has over and above his, if you like, routine work, the medical superintendent is very frequently undertaking administrative work rather than that more specialised type of work which is regarded I would say as more likely to make him eligible for a merit award.—*Dr. McCoull*: We could elaborate on that by letter if there is any doubt about it.

Chairman: I think the Commission has the point.

4950. *Sir Hugh Watson*: Of course as you know the Bradbeer Committee recommended that consultants engaged in clinical work who worked for part of their time in administration should not be prejudiced in remuneration by the faot it did so occupy their time.——*Dr. Skene*: Precisely. That is understood, Mr. Chairman.

4951. Dr. McCoull, in Appendix C to the Bradbeer Report there is a table which shows that throughout England and Wales there appear to be 129 medical superintendents for a certain number of hospitals?——Yes, Sir.

4952. Are these all the gentlemen who act as medical superintendents broadly speaking of hospitals?——*Dr. McCoull*: No. I said we think there are about 400 in the country. These figures have been very difficult to get and even now we are not too certain to about half a dozen of the exact number.—*Dr. Brookes*: May I say there is a very important footnote to that table which explains it.—*Dr. McCoull*: Page 16 of the faotual memorandum gives the number of medical superintendents and deputy medical superintendents in England and Wales at 77, Sir. It is extremely difficult following these figures. Every time we see a new table we get a new figure. We think there are 400 in the country.—*Dr. Skene*: We have confirmation from the Regional Hospital Boards of 11 regions that in these 11 regions there are at least 315 actually in post at work.

4953. *Chairman*: Why is there this uncertainty? Is it because they are treated as consultants in medical practice, because they are doing 32 hours or more a week?—*Dr. McCoull*: We think, Sir, it is because of the nomenclature. Sometimes a man is termed a surgeon superintendent, sometimes a physician superintendent and sometimes a medical director.—*Dr. Brookes*: That is explained in Appendix C of the Bradbeer Report where they say the amount of medical administrative work is much greater. A number of consultants, not classed as medical superintendents in fact devote a considerable amount of their time to administrative duties.

4954. That still does not necessarily affect this question of the number of medical superintendents. I should have thought this was something the Society would have wished to get right in the statistics of the Ministry?——*Dr. McCoull*: We have been trying to do that and have got it out of 11 regions. Three have not replied. We are certain of figures on 11 regions.

4955. Could I ask you to look at this Appendix C of Bradbeer under the heading of "Mental" and "Mental Deficiency", in which it would appear there are in total 44 medical superintendents. In view of the statutory obligation to have a medical superintendent in such hospitals, I should have thought there would have been far more.——There must be far more than that.

4956. There are 130 mental hospitals included in the table.——*Dr. Brookes*: The average number of big mental deficiency hospitals in each region is four: smaller places which have to have a medical superintendent, three. The figure is wrong, Sir.—*Dr. Skene*: May I just say, Mr. Chairman, that the official documents do lend some point to the comment we made in the first paragraph of our memorandum, that the existence of only 77 of us has been recognised in this official document, but we are 400.

4957. Dr. McCoull, this Ministry's Factual Memorandum came out as far as I can remember in July, 1957—it might possibly have been August. There should have been enough time to estab-

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lish the true facts since then.——Mr. Chairman, we started to collect these figures in October.

4958. *Sir Hugh Watson*: I have forgotten how we got on to this. We were talking about merit awards. In your paragraph dealing with merit awards you suggest the setting up of representative regional committees. Could you just tell us a little about the ideas which prompt you to make that suggestion, following on what Dr. Cotton-Cornwall said about the Lord Moran meetings?——*Dr. McCoull*: Can I go back to what I know Lord Moran said quite a lot about to you, that is the Newcastle meetings and set-up there. He devoted a considerable time to that. I was in that group and know of it. Lord Moran comes once a year: a meeting is called for consultants and the meetings as a whole have been very well attended. I think 250 were at the first meeting. The figure has dropped possibly since. Even at a meeting held on Sunday night there were over 100 there. From that meeting in the Newcastle area was appointed a man to go on to a team of four which looks into the case of every consultant in that area and makes recommendations. Middlesbrough, Darlington and Sunderland I think each have similar committees. They go into each case in their own area. It is those committees we think ought to have some official recognition. They ought to be officially known as the recommending body. As it is you see from Lord Moran's evidence, those committees do not report to Lord Moran. They report to a Committee of the Regional Hospital Board, and say what they think to them. Finally Lord Moran meets the Regional Hospital Committee; who else is met nobody knows. I think he said in his evidence he asked individuals what they thought. No one knows who the individuals are—we have a very good idea—no one officially knows who they are, as between small committees who really are representative of the consultants, as between individuals and Lord Moran, and the Regional Hospital Committee he has co-opted. Then a list comes out which you do not see until the next meeting. We think there should be some official small body elected or appointed by the doctors and having some official recognition in this matter.

4959. *Chairman*: Dr. McCoull, it has been suggested and fairly strongly supported by many people in your profession, that the comparatively informal nature of ascertaining the real merits of particular people in these districts works better than a formal official committee system. You feel that is not so?

Sir Hugh Watson: To supplement what the Chairman said Lord Moran described the machinery to us very much as you have described it. He said at the end of the day all the indications pointed the same way; they all pointed to the same people.——I believe that to be true, Sir. I think the whole thing is that if a small committee puts up certain recommendations, places a man very high indeed, and then goes to the regional committee which also places the man very highly indeed and that man does not get a merit award but someone else does, then we think some official recognition of these committees should help that position.

4960. May I take it you are talking principally at the moment, Dr. McCoull, about the C awards?——I am talking about all awards.

4961. Because Lord Moran put it to us there was never any doubt about the A's.——I entirely agree: there is no doubt about the A's.

4962. There was perhaps some doubt but not a great deal about the B's.——Yes. It is largely the C's—the picking of a new man for an award, that is the difficulty.

4963. It was getting the man on to the ladder for the first time?——Yes, that is the difficulty, Sir.

4964. *Chairman*: Is this partly connected, Dr. McCoull, with the feeling that in the particular sphere of mental health there has not been as much recognition as in some of the other major spheres?——That has not come into my mind, but I have figures which I understand you have. The Royal Medico-Psychological Association have put up the figures that have been obtained about psychiatrists. No, I was not talking about that at this moment.

4965. I would like to know whether you think under this system, things have worked out fairly well or not. What do you think?——I think it works out as well as it can do under the system.

4966. Dr. Skene, is that your feeling?——*Dr. Skene*: I am not very closely acquainted with the system in the Liver-

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pool region, because of course, the system appears to be different in each region; but I know there is established in the Liverpool region a committee to advise Lord Moran.

4967. Yes. My question was, do you think the results are very wrong in fact as far as you know?——I think allowing for human fallibility the results are reasonably satisfactory.—*Dr. Cotton-Cornwall*: That is not quite correct. I have a little more intimate knowledge of what is done. The committee you refer to is entirely an informal committee which advises the person Lord Moran consults in the Liverpool region, and the committee as such is not recognised by Lord Moran. I feel, Sir, the point we are trying to make is that although the end result may be very similar to what the end result would be if you had an elected committee making recommendations, that people would feel they were being more fairly treated. "X" and "Y" possibly "Z", are consulted; we do not know quite who is consulted, but it depends very largely on his opinion as to who in this region will get a merit award.

4968. I am talking now about the C merit award. I agree with what has been said about A and B. The difficulty does not arise there.——*Dr. Brookes*: I think, Sir, within my region people are tolerably satisfied. The only point I would make is the very low percentage of awards given to people in mental health.—*Mr. Milloy*: In my region we do not know much about it. I am surprised to hear from the other regions about these regular meetings. Only one meeting has been held in the London area which was when the first distribution of merit awards occurred. They met there and divided up A and B but wanted ten more C's. A small sub-committee of three was set up to recommend these ten. I happened to be a member of that sub-committee. It only met once and has not met again.

Sir Hugh Watson: I think Lord Moran did say he had a different method of dealing with London than the provinces.

4969. *Chairman*: Lord Moran gave a full account of his methods in the verbatim evidence which has been published by the Commission.*

* Royal Commission on Doctors' and Dentists' Remuneration Minutes of Evidence Days 3-4.

Sir Hugh Watson: Could you perhaps in a few words expound to the Commission your general view regarding the place of medical administration in general and mental hospitals?——*Dr. McCoull*: I can really only speak with authority on perhaps the mental and certainly the mental deficiency side. One of the other witnesses might do so as regards general hospitals. I do not think there is any doubt about it that medical administration in the mental and mental deficiency hospital is an absolute necessity. I do not think any other system—shall we say the system as used in most general hospitals now—will work. It will not work because the mental and mental deficiency hospital is a place—a community—where we, the medical superintendent and his staff, have to look after the whole life and living situation of the patient, where everything done inside that hospital has a reaction upon the life of the patient. That is certainly true in mental deficiency. I do not know how far it may be untrue as far as mental hospitals are concerned but I believe the position is the same. There is no way of looking after a person's total life—24 hours a day, perhaps for years, perhaps for a shorter time—than by medical administration. When I say medical administration I mean an administration that has a doctor acknowledged as the head. I leave out the words "medical superintendent"—a doctor.

4970. That means the doctor supervises if he does not deal with the detail of the whole administration of the hospital?——I think the better the doctor the less he does of detail, Sir.—*Dr. Brookes*: I think it is perfectly true of mental hospitals too, but he correlates other duties of the hospital. He acts as liaison officer.

4971. Does that apply to general hospitals also?——*Dr. McCoull*: Mr. Milloy and Dr. Skene can speak for general hospitals.—*Dr. Skene*: If I may, Mr. Chairman, I will say that the position is obviously in practice different in general hospitals in England today, but we have taken the view that the employment of a medical superintendent in a general hospital is highly desirable because the basic fact is that the hospital is simply a building to enable sick members of the public to be treated by doctors. And it seems reasonable that the administration of such an organisa-

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tion might well be carried on by a medical man.

In the Henderson Report on medical superintendents in Scotland, they said that they considered the employment of medical administrators in hospital was desirable and one of the arguments for the employment of these people was based on the part he can play in fostering the integration of the hospital service with other branches of the Health Service. I think that is a particularly strong reason for having one medical man recognised as an administrator, particularly in a large hospital and particularly in urban districts where there are large hospitals and where hospitals tend to become isolated units unless there is a discriminating medical man who continuously undertakes these responsibilities among others.

4972. I think I am right in saying in England the majority of general hospitals do not have whole-time medical superintendents?——*Dr. McCoull*: That is so, Sir.

4973. They have consultants who are part-time?——No, Sir, they have lay secretaries.

4974. Yes. They also have consultants who are part-time medical superintendents, although you call them physician superintendents or medical directors?——No. The average general hospital has as its chief officer a layman who is the group secretary and he is in charge of that hospital.

4975. *Chairman*: There is very often a lay secretary as well who is subordinate to the group secretary?——Subordinate to the group secretary.

4976. I think you said earlier that of your 400 possible members only about 7 or 8 per cent., that is to say 25 or 30 people together, would be in general hospital?——I would like to appeal to our secretary to make sure that is right. —*Dr. Brookes*. I think that figure is rather small; there are more than that—certainly more in the London area.—*Dr. McCoull*: Dr. Skene has the figure. *Dr. Skene*: I have not the figure of members of the society but have the figure in respect of hospitals other than mental and mental deficiency hospitals in the eleven Regional Board areas to which I have referred. It is this, that there are 184 medical directors, superintendents and physician superintendents of general and special hospitals.

4977. How many in mental and mental deficiency?——131. There are 315 superintendents altogether. But whereas the 131 mental and mental deficiency medical superintendents administer 162,000 beds, in the 184 other hospitals medical superintendents administer only 50,000 beds, that is to say, all the mental beds have a medical superintendent under statute. Only 60,000 out of the total number of general beds, which is 250,000, have medical administrators—60,000 out of 250,000.

4978. This rather modifies the figures you gave earlier about 90 to 95 per cent.——*Dr. McCoull*: It does; I said I was making an estimate.—*Dr. Skene*: Unfortunately we have had some considerable difficulty getting these figures and the last figures I received from the Ministry of Health only on our way here at 2 p.m.

4979. *Sir Hugh Watson*: Can you tell us the importance of the legal responsibilities relating to the freedom or custody of the patient borne by the medical superintendent?——*Dr. McCoull*: In the mental hospitals that is a very great responsibility. It has to do with the freedom of the subject, whether a person is just going to be kept in the mental or mental deficiency hospital or not. Dr. Brookes can speak better of the mental hospital: I speak as to the mental deficiency hospital. The work has been tremendous. New legislation has placed very increased responsibility on us, in spite of the fact that our legal responsibility is now largely being lightened by new regulations. A mental deficiency patient coming into hospital had to be certified at the end of the year; he was certified on admission and re-certified at the end of a year, then at the end of five years; that is going on all the time. Now we are taking in patients where this re-certification will not be necessary, but early experience shows that the responsibility of taking in mental defectives in an uncertified condition is certainly going to be much greater than before. There is no doubt of the responsibility—I am not talking of rights or wrongs—this informality is going to put on the doctor a very much increased responsibility. We are not objecting to it. It has ceased to be legally our responsibility.

4980. *Chairman*: Could I ask, Dr. McCoull, whether in the ordinary mental deficiency hospital this responsibility invariably comes directly on to the medical

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superintendent, or whether it is simply he has the ultimate responsibility but doctors under him in fact take the decision in most cases?——I speak of a hospital where I am the only consultant. In my hospital the other doctors take their share of responsibility, but in questions of doubt I am the person who has to decide. I am the person they come to. If necessary I am the person who says what we will do.—*Dr. Brookes*: There are additional duties—safeguarding of the patient while in hospital.

4981. *Sir Hugh Watson*: Is it possible to say approximately how much time is involved in clinical work and how much in administrative work?——*Dr. McCoull*: This is all bound up in this question I found so difficult to interpret in reading the evidence given to you. Everyone will speak as though doctors work a 38½ hours week. As medical superintendent I can double that almost every week. I would say that the actual administration as administration does not take very much time. There are other people who do this work—the group secretary, the group engineer, they see to all these things. There is other work which is looked upon by some people as administration but in our opinion is purely medical. I had anticipated this question. On Saturday having had a busy day I started writing about 5.30 and finished after 10. I wondered if I would get this question and wrote down exactly what I had been doing. I can put it in to you. It is just a list of about 40 items as they occurred—the letters I dictated and the various actions I took. Looking over that I am quite certain that had to be done by a doctor and it is administration. You are not touching a patient; I did not see a patient during all that time. It is difficult to say how much the proportion of clinical time is when you do not know the total to start with and do not know what the administrative part is. You do not see a patient, nor do you order coal or flour or anything of that kind. I certainly do not.

4982. You were dealing with medical administration?——Entirely. If you are interested in the question I have got it somewhere written out.

4983. *Chairman*: If you would like to send us that for our private guidance, the Commission would be glad to have it.——Yes, Sir, I will send it on later.

4984. We have the point. You are dealing entirely with medical administration, not with lay administration nor with the actual clinical job of seeing patients.——I hope it is understood. I was asked to give a proportion of time but with so many unknowns I cannot give a definite proportion.

4985. *Sir Hugh Watson*: How far is the medical superintendent responsible for the clinical work of other consultants of the staff?——I would say not at all. I think as a medical superintendent he has got to see that outside consultants turn up for clinics, that they come in on time and do not keep nurses waiting all the day. I would say he has got to be responsible for seeing that the consultant is fully looked after, has the equipment he needs and is supplied with all his wants. I think for the part-timers the medical superintendent has got to see their treatment is properly carried out, that the nurses are doing their job, and so on, but as far as clinical responsibility is concerned I do not think the medical superintendent has any responsibility whatever.

4986. Dr. McCoull, in your paragraph 10 (*f*) I think you suggested that the Senior Hospital Medical Officer grade might be abolished. What do you suggest for its replacement?——It may be others may want to speak here, too, Sir. I think largely we think there ought to be a broadening out of the consultant grade. We do not think that some form of junior or assistant consultant is the right answer. Perhaps Dr. Skene has got views on that.

4987. *Chairman*: I would like to be clear on your own answer first. You say a broadening out; you do not want a junior consultant or assistant consultant. Do you mean simply an addition to the number of consultants? Is that what broadening out means?——I do not mean an addition to the number of consultants. I mean a broadening out of the salary scale so that a man will have a longer term to go and perhaps start earlier—a broader remuneration term, not more consultants.

4988. But the present Senior Hospital Medical Officers for instance, in terms of your answer would be consultants, but within a much broader salary range. Is that right?——*Dr. Cotton-Cornwall*: No, Sir. We have not said the present

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Senior Hospital Medical Officer should be a consultant. We think the grade should die out as such and in name, but we think those left in that grade should have a regular review of their status because we do know of Senior Hospital Medical Officers doing consultant work. We would feel this really cannot be tackled until there has been a whole general review of hospital staffing, and as you know a Working Party has been set up to that end. I would feel, speaking broadly, the second memorandum submitted to you by the B.M.A. has dealt with this remote problem very fairly and very fully.

4989. *Sir Hugh Watson*: I read that memorandum last night in point of fact, or the night before. I would agree this is fully dealt with there. Of course, as you say the setting up of a Working Party has largely taken this matter away from this Commission.——I would feel, and most of us feel you cannot really talk about rearranged things until we have got a much greater knowledge of how things have worked so far. All we know is the present Senior Hospital Medical Officer grade has caused tremendous frustration, as has been brought out in the B.M.A. document. People who were in the service before 1948, again as I think has been emphasised very clearly in that document, feel in many cases they have been very unfairly treated vis-à-vis colleagues who before 1948 were considered their equal.

4990. *Chairman*: You said some of your other colleagues might wish to speak on this question?——*Dr. McCoull*: No, I do not think so.

4991. *Sir Hugh Watson*: There is a small point on paragraph 11. You suggest the salary of a junior hospital officer below registrar grade should be raised. I suppose you do not mean house officer grades should be given this additional remuneration because most house officers are not even fully registered?——We were thinking there, I think, of the Junior Hospital Medical Officer.—*Dr. Cotton-Cornwall*: The Junior Hospital Medical Officer. I am afraid one word has been missed out. The number of people is very limited in a more or less permanent grade.

4992. *Chairman*: I think we understand that is quite different from junior hospital officer.——I apologise, Sir. It should be Junior Hospital Medical Officer. —*Dr. McCoull*: Could we come back on this ? I am not certain where I am—I am sorry. I have got Dr. Brookes down as a person who knows something about this; I am not sure I do.—*Dr. Brookes*: I do not really. As a matter of fact I put this answer down, but the Commission's question really refers to registrars. Our answer is a little out of place. We were concerned about the salary, not of the junior hospital medical officer, but of the junior hospital officer below the registrar grade. We were concerned with the salary in relation to the charges made for these men living in hospital.

4993. *Sir Hugh Watson*: We have had that point made to us. We come now to the real body of your memorandum, which is contained in your paragraphs 15 to 20. In paragraph 20 you say for the reasons set out in the preceding paragraphs your Society argues that a medical superintendent should be given extra remuneration over and above his purely clinical colleague. We know the reasons: they are the requirement of responsibility, the burden of administrative work and the social duties attached to the post. Finally you suggest there should be something added in order to encourage recruitment in your branch of the medical profession. What exactly do you mean when you say a medical superintendent should be given extra remuneration over and above his purely clinical colleague? ——*Dr. McCoull*: We think, Sir, because of all the things you mention and from the fact we are more completely wholetime than anyone else and the fact we do carry a burden of responsibility which no one else in the profession carries, that there ought to be some remuneration attached to that aspect of the job over and above what is given to us as consultants.

4994. Are you talking about a wholetime consultant?——Yes, Sir.

4995. You are, I see. Then, of course, what Bradbeer says about that is—I think he was talking about part-time consultants—a consultant who is also employed as medical superintendent should not suffer financially because of such employment. I understood that to mean he should be paid for the sessions in which he was acting as medical superintendent on the same scale at which he was paid for the sessions when he was acting as consultant. Would you agree with that?

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——No, Sir.—*Dr. Skene*: I think the position is that the Ministry recognise that if a medical superintendent spends 9/11ths of his time as a consultant and the remaining part of his time in a whole-time appointment undertaking medical administrative duties, he is paid as a consultant as well. In other words he is paid as a whole-time consultant, although 2/11ths of his time is spent on medical administration. But if he only undertakes 8/11ths clinical and spends 3/11ths in medical administration duties, then of course, he is paid for his 3/11ths at lay administrative rates and not as a medical man at all.

4996. *Chairman*: He stands as a medical man for 8/11ths but not for the 3/11ths?——That is what I think, the reference in Bradheer means, that he does not suffer providing he is predominantly a clinician—a clinician for 9/11ths of his time.

4997. Where would you draw the line? Presuming only 1/11th is clinical and 10/11ths is administrative you would not expect him to be paid entirely as a clinician?——That is so.

4998. Where would you draw the line? ——I do not think I can say where the line can be drawn, except to say this, Mr. Chairman. If a man is a consultant physician for example, in a hospital of 250 beds. and is also the physician superintendent, it is quite understandable that he will be able to undertake the medical administration of that hospital in 2/11ths of his time. If he is medical administrator of a hospital of 1,250 beds, it is less likely he can undertake great responsibility and continue as a clinician and it seems anomalous that for undertaking a more important, onerous task, that he should suffer financially as compared with his colleague who is doing a similar task in a small hospital with less responsibility, which is in fact what happens under the present arrangements.

4999. Are you talking of general hospitals?——General hospitals and sanatoria.

5000. You pointed out that big general hospitals on the whole will not have medical superintendents.——My recollection of what was said, Mr. Chairman, is that a very considerable proportion of general hospitals do not have medical superintendents, or put another way a considerable proportion of general hospital beds are not under medical superintendence. But in fact a very considerable number of the really large hospitals do in fact have medical administrators. I think I am right in saying that all the general hospitals of over 900 beds which are not, of course, teaching hospitals, do have medical administrators. That of course, raises this particular point: there is a very considerable administrative task for the medical administrator of such a large hospital and he would be the one likely to suffer if he was not prepared to undertake 9/11ths of his work clinical and 2/11ths administrative. That in fact is how it works out. I think that many medical administrators of large hospitals are managing to do 15/11ths.

5001. *Sir Hugh Watson*: It appears from Appendix F to the factual memorandum, page 79, that in point of fact consultants who do 32 hours of work, which I make to be 9 sessions, are paid as if their work were wholly clinical.—— Yes, Sir.—*Dr. Skene*: May I ask for clarification? When you say consultants, you mean medical superintendents who are consultants?

5002. Yes, I mean medical superintendents who are consultants. I was talking under reference to this Appendix; you are quite right. Does that satisfy you, Dr. McCoull, or does it not?—— As long as you do not think, Sir, that a medical superintendent's week is made up of 11 sessions: 9 of them clinical and the administrative work done in 7 hours, because that does not apply, not to anybody I know. It is when figures are given that are dependent on this total working week of 38 hours, that frankly I get lost because we are all working so much more time. One's working week does not end at 38 hours.

5003. Having had this very interesting discussion, what I am trying to get at now is this. In your paragraph 20 you say: "extra remuneration over and above his purely clinical colleague". What I want to know now is does Appendix F fulfil your requirements in that connection?——*Dr. McCoull*: No, Sir.

5004. It does not?——No, Sir.

5005. What do you want to substitute for it, what criteria?——We think we ought to be paid as consultants, if we are consultants, for our clinical work,

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and we think because we take this added responsibility as medical superintendents there ought to be a component in our total remuneration which covers that point.

Chairman: Have you any figure in mind?

5006. *Sir Hugh Watson*: Before we come to that, with great respect, what criteria would you suggest should be employed in appraising that figure?——We have talked that over. We think there are other things than the counting of beds and heads. We do not like the counting of beds and heads very much, it makes for difficulty between small and large hospitals. But we think at the present moment that size has to count largely in any method you get, and the number of beds is as far as we have got, although we do realise there are other matters which would come into the fixing of any scale.

5007. *Chairman*: As to size, apart from the number of beds, there would be the number of out-patients?——Those are the other things. When I say beds, you have got to consider the hospital that has few beds but lots of out-patients. Each hospital with a medical superintendent would have to have a number fixed after consultation.

5008. I am trying to find what you meant when you agreed it was largely a question of size, but that it was not enough to base size on the number of beds. If it is not beds, it is out-patients?——*Dr. Cotton Cornwall*: It would be the commitments of the hospital, the type of work done. For example, the acute general hospital would have a much more rapid turnover than a mental hospital.

5009. *Sir Hugh Watson*: The criteria you would apply would differ according to the type of hospital?——I think they would have to.

5010. Can you help us any further? You say you do not like counting heads or beds.—*Dr. McCoull*: We thought, if new criteria came into being, that there must be a ceiling to anything that is awarded for this responsibility factor. Where you have got a large mental hospital with two or three thousand beds it is quite obvious there is a size over which good administration ceases, and we do not think there is any case for putting any such scale above a certain figure. We are suggesting something new, and we have not got exact figures to put before you. We would have to have a thing like that accepted before we could give you much details.

5011. *Chairman*: I think Sir Hugh and I were both wanting to understand just what it is you have in mind and how it would work; because so far I am left with a rather vague impression of something very complicated that would be a matter of individual assessment and judgment in all cases.——*Dr. McCoull*: It would be no more complicated than in some other salary scales attached to many hospitals. There are various people in hospital I think who are paid on a points basis. I do not want to pursue this too much, because obviously I cannot give details of it, but there should not be too much complication about it. Once fixed, they would be fixed for all time.

5012. You do not want a points system?——Not necessarily.

5013. They would be assessed by various factors, varying to some extent in different kinds of hospitals?——According to the responsibility and the work done in the running of the hospital, and the size.——*Dr. Skene*: It is an attempt to equate the remuneration with the total administrative load in a particular appointment. That is not done at the moment.

5014. *Sir Hugh Watson*: Is this not somewhat comparable to the responsibility pay given to certain schoolmasters?——*Dr. McCoull*: I did not even know that schoolmasters got a responsibility payment.

5015. It is a long time since you and I were at school, but I believe the head of a department, for instance the head of a modern languages department, gets, over and above his salary as a teacher of that language, something per annum because he is responsible for a department which comprises so many staff.——*Dr. McCoull*: I would say we are thinking along those lines.

5016. *Chairman*: But the consultant is the head of a department as a rule.——He is the head of a department; but if you are thinking of a consultant at the head of his own department you are thinking of some different kind of responsibility than the responsibility which the medical superintendent has in his charge of a hospital.

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5017. Just one other question; I thought I saw what you were getting at; you were saying you were nine-elevenths clinical, and it was assumed that two-elevenths is administrative; but in fact you are doing eleven-elevenths clinical and administration over and above that. Is that so?——I am not quite sure that I follow. Quite frankly, I think this nine-elevenths and two-elevenths does not count, because we are all doing more than nine-elevenths, and we are not accustomed to thinking of part-time on a sessional basis. The answer is, I suppose, on paper you could expect us to be doing nine-elevenths plus two-elevenths administration, but the answer is of course that we are doing something far more.—*Dr. Brookes*: Apart from that there is an increased responsibility in that we are not only called upon sometimes for decisions which are purely clinical, but we are also called upon frequently for administrative decisions, at any time of the day and night. It is simply that we are standing by, so we are called upon to give the administrative decisions as well as the clinical decisions. This goes on the whole time, as long as we are on the premises, and we live on the premises.

5018. *Sir Hugh Watson*: You are literally on call 24 hours a day?—— Yes.

5019. Dr. McCoull, your remuneration so far has been dealt with in Whitley B, am I right?——*Dr. McCoull*: Yes.

5020. In your paragraph 14, in answer to our question XX, you say that there is general dissatisfaction with the Whitley Councils. Have you put forward this point of view from the Staff Side in Whitley B—the view you are expressing to us now?——I am quite certain we have expressed dissatisfaction from time to time with minor things, with individual items.

5021. Have you put forward this point of view about the necessity for consultants who are also medical superintendents receiving additional remuneration qua medical superintendents?——I will ask our secretary to answer that.—*Mr. Milloy*: We took this up some years ago to get the administrative salaries for medical superintendents clarified; we could not agree and went to arbitration, and the arbitration tribunal gave us a much higher salary for the purely administrative work.—*Dr. Brookes*: That applied to men in the service before the appointed day, having been taken over. There was no grading then in the medical scale, so they were given an arbitrary scale which we think was grossly unfair, because they were being paid a salary before the appointed day which was higher than the salary received by those of us who have since been graded as consultants.

5022. *Sir Hugh Watson*: When you ventilated this matter at Whitley B, that was the last time this was brought up; that was some years ago?——*Mr. Milloy*: Yes, that is so. I was going to speak about it in reference to another paragraph. We are concerned with the state of some of our members who think they have been unfairly treated. There was one appointment to a large hospital shortly before the appointed day; it was considered to be a very super job, and the man who got the job was considered by all his colleagues in the service as being the best man for the job; yet after the appointed day he found himself in a worse position than his colleagues. Everybody agreed in that hospital that he had a full-time administrative job.—*Dr. Brookes*: One of the reasons why we are worried about the medical administrator and the inducement to get into medical administration, is that it is quite obvious when the Health Service came in the medical administrator was regarded as being very much inferior to his clinical colleagues.

5023. Regarded by whom?——It is difficult to say—by the very fact that he is not paid as much as the consultant —I regret to say by some of his own colleagues, part-time consultants, who do not get paid as medical superintendents. He is a person in a position, perhaps, to read the riot act occasionally to some of his colleagues, whereas the lay administrator cannot.—*Dr. Skene*: Which is no mean additional responsibility.

5024. While we are on that subject, to what extent could the functions of dealing with staff, whether medical or lay, technical or non-technical, be dealt with by a person with reasonable tact and personality and some administrative knowledge and experience?——*Dr. McCoull*: You mean without medical qualifications?

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5025. Supposing you have got a man, let us say an accountant or a solicitor, who was put in as a lay administrator of a hospital, a man who had some business experience. Do you think he could, given the personality, tact, a sense of humour, understanding, deal to a very considerable extent with the problems about which you have been talking to us?——It sounds easy to say yes to that—if such a man existed, with all those qualities. But there is something in hospital life, there is something over and above all that that has to be done. Dealing with staff, yes. Is he going to be able to deal with staff when the doctors find they have not got the right staff or they have not got the right numbers of staff. There are so many questions which are so difficult for doctors to get over. There is this component in a hospital which means binding everybody together. We reckon that we have these people in the hospitals who are capable of dealing with staff, who can obtain good staff relations, who can deal with ordering the flour, getting the coal, seeing that the engines run. There is this total overall component of looking after a hospital as a whole; and frankly, I do not think an accountant or a business man or a lawyer could do it well.—*Dr. Skene*: Could I answer Sir Hugh's question? I think the paragon to whom he refers could in fact undertake these duties for a considerable part of the time; but when it came to a medical decision he would be dependent on a medical staff committee, or some medical adviser. Medical staff committees do not meet at midnight on a Saturday when a snap decision may well be required, and that is where we feel that there is undoubtedly at least the desirability of having a medical man undertaking these day-to-day responsibilities, because there is no saying when the duty becomes one for a doctor. Part of the time a competent colleague without medical training could, no doubt, undertake some part of the work. But who is to say when it may become entirely a medical question, and the answer is not obtainable at short notice on high days and holidays.—*Dr. Brookes*: An important point is that the medical administrator has an advantage over the lay administrator; but I am not saying that lay administrators are bad, because I can number among my colleagues some lay administrators who are extraordinarily good. But the interesting thing is that they have developed a medical outlook, even to the extent of reading medical text-books, and have developed a working knowledge of the doctors' side. But that type of man is rare.

5026. *Chairman*: Have you any other point you wish to raise? If you have other points, by all means raise them.——*Mr. Milloy*: I would like to raise a point which was mentioned in paragraph 21, on behalf of a number of my colleagues. I did mention one case, but there are other cases. I think it should be considered whether any of these people who have been graded as Senior Hospital Medical Officers should not be graded as consultants. We cannot comment on the merits or the demerits . . .

5027. *Sir Hugh Watson*: I do not think that is a matter we can raise here. ——Maybe, Sir, but it concerns the grading on which remuneration is paid.

5028. With great respect, the Chairman will no doubt give a ruling on this, I do not think we can deal with gradings, Mr. Milloy.——*Dr. Brookes*: I do not think we are concerned so much with the fact that these people have been given a clinical grading. These are people who are administrators and do mostly administrative work, very little clinical work; but in order to fix a rate of pay they have been given a clinical grading. That is what we are worrying about. A number of our colleagues, about seven or so, are suffering rather badly as a result of this. They were medical administrators purely and simply before the appointed day. Having come into the Health Service, they have been graded as Senior Hospital Medical Officers, to act as medical administrators; whereas before that they were on a par with those of us who were medical administrators. We do feel that they should have some consideration.

5029. *Chairman*: Can I ask Dr. Brookes whether it is that most of you remained about the same in remuneration, and they were down-graded, or that most of you were up-graded and a few were left?——In effect it is very difficult to say, because, frankly, I consider I was considerably better off with my salary and emoluments then than with the salary and emoluments that I am getting today. But on the whole we were up-graded on paper, and these people were left behind.—*Dr. McCoull*: There is one thing further I would like

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to say. I do not know how far I am carrying my colleagues with me. In the evidence given to you by other people I cannot help feeling that this question of freedom does rather come into our pitch—such a statement that being a part-timer stops a man from feeling like an officer in Whitehall or Savile Row. I am quite certain that being whole-timers, being medical superintendents, gives us no such feeling. I do not want to feel that such statements are going unchallenged by a whole-time body of people. We do not feel like that, and I would not like any possible imputation by that sort of remark being tied up to people like ourselves.

5030. *Chairman*: You consider you are doctors as much as anybody else? ——I was a general practitioner doing the work I am doing now until 1947, except for the war years. I have been a part-time Medical Officer of Health, a general practitioner, and a part-time consultant in psychiatry. I feel just as free now as I did before; and repeatedly during the evidence that I have read I have got angered that people should think these things of us.—*Dr. Skene*: I think, if I may be permitted to express a point of view which is not unique, that one would agree absolutely with Dr. McCoull. The whole-time medical superintendents have no sense of restriction whatsoever, and it may well be due to the fact that there are other colleagues who have an option as to whether they are whole-time or part-time.

5031. *Chairman*: Thank you. If there is nothing else, that concludes this session.——*Dr. McCoull*: Could I thank you on our behalf very much indeed for having us here and being so kind and patient with us.

(*The witnesses withdrew*).

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

21

Twenty-First Day, Friday, 31st October, 1958

WITNESSES

Joint Consultants' Committee

LONDON
HER MAJESTY'S STATIONERY OFFICE
1959

FOUR SHILLINGS NET

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Witnesses

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TWENTY-FIRST DAY

Friday, 31st October, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER
MR. A. D. BONHAM CARTER, T.D.
MR. J. H. GUNLAKE, C.B.E., F.I.A., F.S.S.
PROFESSOR JOHN JEWKES, C.B.E.
MR. I. D. MCINTOSH, M.A.
SIR DAVID HUGHES PARRY, Q.C.
SIR HUGH WATSON, D.K.S.
MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C.
MR. J. B. HUME
Joint Secretaries

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

(i) The quality and quantity of recruits (*a*) offering themselves and (*b*) accepted for training as medical students.

(ii) The quantity and quality of newly qualified doctors.

(iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.

(iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).

(v) The position and prospects of a newly qualified doctor.

(vi) Any trend to excessive resort to certain branches of the profession at the cost of others.

(vii) The relative advantages and disadvantages, financial and otherwise, of service as:—

(*a*) a principal in single-handed general practice,
(*b*) a partner in general practice,
(*c*) a whole-time consultant in the National Health Service,
(*d*) a part-time consultant with the maximum number of sessions,
(*e*) a part-time consultant with only a few sessions,
(*f*) a Senior Hospital Medical Officer,
(*g*) a doctor in any other sort of practice or employment.

(viii) The difficulties encountered by members of the registrar grades.

(ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.

(x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.

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(xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.

(xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in tbe National Health Service.

(xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.

(xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.

(xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.

(xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.

(xvii) Special considerations of which account ougbt to be taken in discussions of medical remuneration.

(xviii) Specific proposals for medical remuneration.

(xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.

(xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.

(xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

Note: The following memorandum was not submitted by the Joint Consultants' Committee as direct evidence to the Royal Commission. It was produced as an informal statement in response to the Commission's request, at an early stage of their proceedings, for a brief explanatory note on the functions of hospital medical staff below the grade of consultant.

HOSPITAL MEDICAL STAFF

The functions, responsibilities, etc., of the grades below the consultant

Senior Hospital Medical Officers

1. It was realised at the outset of the Service that some men holding permanent hospital posts, either whole or part-time and who were not of the professional standing of consultants, would have to be embodied. These consisted of two main groups: (1) medical officers of local autbority hospitals and of local authority health services, such as tuberculosis officers. These were almost entirely whole-time officers; (2) general medical practitioners who held posts of some seniority in hospitals in their districts, such as physician or surgeon, but who were not of consultant quality. Such posts were not infrequent in some voluntary hospitals in provincial towns.

2. To assess the professional standing of these transferred or "taken over" medical officers professional grading committees were set up under ministerial authority, and, subsequently, owing to many requests, several appeals were heard from those who were dissatisfied.

3. There may, at times, be some overstatement of the S.H.M.O. case, as is perhaps only natural.

4. It has been a hope of consultants that the S.H.M.O. grade would decline and possibly eventually disappear. Far from this being the case it has actually tended to increase in numbers from new appointments.

5. An agreement was reached between the Joint Consultants Committee and the Ministry of Health soon after the N.H.S. had begun upon the principles that should govern new appointments to the grade; it having been found necessary to make

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new appointments. A copy of this agreement, which is still valid, is attached as an appendix. It has prevented serious abuse in the making of appointments. There is no doubt that many hospital authorities would have made S.H.M.O. appointments when they should have appointed consultants, for reasons of economy. It will be seen from the agreement that hospital authorities cannot appoint S.H.M.Os. in the main clinical fields to ease the normal clinical responsibility of hospital physicians, surgeons and obstetric surgeons. The agreement does not apply to Scotland.

6. It was agreed that the S.H.M.O. grade should continue where offices did not call for consultant skills, while being posts that should be (*a*) senior and (*b*) permanent. The type of post is well defined in the attached S.H.M.O. circular.* It will be seen that the S.H.M.O. will be appointed, for example, for refractionist work in an eye hospital, but not for the full range of operative ophthalmology, such work necessitating a consultant. With the development of the service since 1948 it is probable that some changes should now be made in the S.H.M.O. regulations; e.g. the post of non-operative obstetrician is no longer needed and there is little use in the service for the S.H.M.O. diagnostic radiologist, who may well prove a menace.

7. Constant vigilance has been necessary to prevent abuse of the S.H.M.O. circular and to stop the consultant service being improperly diluted. There is no doubt this vigilance will have to be continued in the future, against dilution from more than one direction.

8. Whilst an S.H.M.O. newly appointed should not be given consultant responsibilities, some S.H.M.Os. who were transferred from hospital posts they already held in 1948 have been and are so acting. Nevertheless, this does not mean that they should thereby be re-graded as consultants. Consultant grading is a personal one, dependent upon the possession of the appropriate qualifications, training and ability.

9. The claims of some S.H.M.Os. to be paid at consultant rates because they are at present holding posts that will be filled by consultants when they retire are now under examination in Whitley. The granting of any such claims will not carry with it re-grading as consultant, which grading it must again be emphasised is a purely personal one.

10. It is most important for future efficiency of the Service that the high standards of qualification and efficiency of the consultant be rigorously maintained. Any compromise here would begin an insidiously spreading decline in the whole Service. New S.H.M.O. posts will be found most often today in pathology and psychiatry where they provide an "alternative path" to a consultant career and are often held by young men of the registrar type.

Junior Hospital Medical Officer

11. This grade was created to employ a junior type of career officer. It consists chiefly of those who were junior or comparatively junior hospital medical officers in local authority hospitals before 1948. There are no regulations beyond the Terms of Service for new appointments to this grade and few new appointments are made. All hope, and there is little doubt, that this will prove a shrinking grade that will eventually disappear.

Registrars

(a) *Senior Registrars*

12. These officers, together with the Registrars, are found occupying the middle field of appointments between House Officers below and Consultants above.

13. This type of officer began to appear in our teaching hospitals a little less than a century ago as modern medicine began rapidly to advance.

* Ministry of Health Circular { RHB (50) 96 / BG (50) 88 } dated 3rd October, 1950.

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14. He is not a career grade officer, but one holding an office of limited duration under consultant direction, pending settling down to a permanent career either as a consultant himself, if he wins a post competitively, or in some other branch of the profession.

15. A Senior Registrar holds a four-year post, renewable or extendable at present under certain conditions. The establishment of the posts in the various specialties is controlled in numbers by the Ministry of Health to adjust as far as possible the holders of posts to anticipated vacancies.

16. The Senior Registrar will almost invariably possess the higher academic qualifications of the consultant before he obtains his post. As a more senior grade than the Registrar he will be capable of assuming, under his consultant chief, more advanced duties. Even he should not work independently of a consultant chief and is to be regarded as under final consultant training. It is probable that there are too many senior registrars, especially in the main clinical streams in non-teaching hospitals, doing too much unsupervised consultant work that consultants should be appointed to undertake.

17. Much of what is said under this section applies also to the next grade—the Registrar—as, owing to the rationing of Senior Registrars, a Registrar, who belongs to an unrationed grade, has to be appointed to carry the same sort of responsibilities.

18. There are two aspects to the Senior Registrar: (1) his necessary place in the hospital staffing plan in order that the work of the hospital may be done, and (2) his position as a young and temporary officer training for consultant rank, to which he will have to attain competitively.

19. He is the direct and personal assistant to one or more consultants; he is their right-hand man. The senior registrar will probably have been a registrar for at least two years previously and before that will have held several house appointments, all these posts having been obtained in competition. He will be approaching, or may be more than, 30 years of age.

20. By working as a consultant's assistant he carries out essential work on behalf of his chief and receives advanced training by precept and example. In the clinical fields he will supervise the house officers in their initial history taking and management of cases and will instruct them. He will take decisions when matters become too serious for them. Thus he will either carry out more complex procedures himself or report the case, if necessarily urgently, to the consultant.

21. Depending upon his degree of skill the consultant will depute to him work of varying responsibility. He will deputise for the consultant for short periods—this is part of his training.

22. It will be seen that Senior Registrars consist of the exceptionally able, competitively chosen, younger men and women of the medical profession.

(b) *Registrars*

23. These are the next rank below that of Senior Registrar. Their two-year posts are renewable without limit. The majority probably serve for two to four years and not more. A great deal of what has been said above of the Senior Registrar's grade applies also to this younger grade. It is easier for an officer to leave the hospital service and enter, e.g. general practice, from this grade than from the more senior one. With restricted numbers of Senior Registrars the Registrar in many instances has had to be appointed to carry the same sort of responsibilities.

24. In teaching hospitals both Senior Registrars and Registrars have an important part in the teaching of students.

25. In all hospitals in both grades they play an essential part in the medical organisation of ward and out-patient work. Their duties in the special departments, such as pathology, are of similar quality.

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(c) *House Officers*

26. These junior officers, like registrars, occupy a double role. They are recently qualified medical men and women who are adding to their efficiency by holding these postgraduate posts. On the other hand, the work they do is essential to the hospital.

27. They can be regarded as in the front line amongst the medical staff of a hospital. They are the first to see a patient upon his admission, to take the history, to make the first clinical examinations, to administer the first essential treatment. They will commonly work under the immediate supervision of a registrar, but they will be directly attached to a consultant chief as his "House" Officer and will be in frequent direct contact with him.

28. They will be his most junior personal assistants. They carry out, under supervision and instruction, all the routine treatment of patients in the wards unless it is of a degree of skill that is beyond them, and carry much responsibility for the admission of cases.

29. To increase the efficiency of all doctors it is now compulsory for every qualified man to perform one year of House appointments before he can be registered and there can be no doubt as to the wisdom of this regulation. Two six-months posts have to be held before registration in either Medicine, Surgery or Obstetrics. A third post after registration will receive higher pay. There is then available the post of Senior House Officer, of one year's duration, the duties beginning to approach those of a Registrar.

MEMORANDUM OF EVIDENCE TO THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

CONTENTS

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INTRODUCTION

1. The Joint Consultants Committee was established in 1948 by agreement between the Royal Colleges, the Scottish Royal Medical Corporations, and the British Medical Association.

2. The Committee consists of 17 persons appointed as follows:

3 by the Royal College of Physicians of England

3 by the Royal College of Surgeons of London

2 by the Royal College of Obstetricians and Gynaecologists

1 by the Royal College of Physicians of Edinburgh

1 by the Royal College of Surgeons of Edinburgh

1 by the Royal Faculty of Physicians and Surgeons of Glasgow

6 by the Central Consultants and Specialists Committee of the British Medical Association.

3. From its inception the Committee has worked in close association with the representatives of hospital dental staff, who have the same terms and conditions of service as hospital medical staff. An observer appointed by the British Dental Association has attended its meetings. Recently the Committee has taken steps to improve this liaison by inviting the British Dental Association to appoint two representatives as full members of the Committee.

4. The terms of reference of the Committee are:

"To negotiate, in respect of England and Wales with the Ministry of Health, in respect of Great Britain with the Ministry of Health jointly with the Department of Health for Scotland, and in respect of Scotland through the Joint Consultants Committee (Scotland) with the Department of Health for Scotland, on all matters concerning consultants and hospital practice other than those within the scope of Committee B of the Medical Whitley Council."

5. Since 1948 the Committee has been in close touch with the Ministry, bringing to its notice problems referred to the Committee by its constituent bodies or by other medical organizations; and the Ministry has often invited the Committee's advice on the planning and development of the hospital service.

6. Matters relating to the terms and conditions of service of hospital medical staff are outside the remit of the Joint Committee and are dealt with by Committee B of the Medical Whitley Council, the Staff Side of which is appointed by the Joint Committee. In view of the close relationship which often exists between matters of policy or principle and terms and conditions of service, the Joint Committee has found it desirable to appoint its own members as the Staff Side of Committee B. Thus the members of the Joint Committee have an intimate knowledge both of the terms and conditions of service of hospital medical staff and of the many hospital problems with which the National Health Service has been confronted since its inception.

7. In preparing the following statement the Committee has tried to answer the questions posed by the Royal Commission in its notes for the guidance of bodies invited to give evidence, so far as it is within its competence to do so.

THE YOUNG DOCTOR AND HIS CHOICE OF CAREER

8. Upon qualification the young doctor has to serve for twelve months in approved hospital resident appointments before becoming eligible for full registration, which entitles him to practise his profession independently. Immediately after this probationary period the male doctor normally undertakes at the present time two years of national service, and he is thus about 27 years of age before he can take any decisive step in relation to his professional career.

9. The main fields open to him are (1) general practice; (2) hospital practice; (3) university teaching; (4) research; (5) Government or local authority employ-

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ment; (6) the Armed Forces; (7) the Oversea Civil Service; (8) industrial medicine; (9) emigration. The majority choose either general or hospital practice.

10. It is possible to he engaged in more than one of these fields—for example, in hospital practice and teaching or research; but it is more difficult to-day than in former years for a doctor to undertake both general practice and hospital work.

11. The young doctor will usually begin his professional life with a decided preference for a particular branch of medicine, though he may change his plans as practical experience modifies his initial preference, or through force of circumstances. In general, under present conditions, the longer he delays his final choice, the poorer become his prospects.

12. A career in the hospital service entails a long period of training at comparatively low rates of remuneration. The prospective consultant must try to acquire higher professional qualifications, in the examinations for which only a small proportion of the candidates are ultimately successful. He must then face keen competition for appointments in the most desired hranches of hospital work (medicine, surgery, and obstetrics), though the less-favoured specialties are more readily entered. Moreover, unlike the general practitioner he is compelled to retire at age 65, so that even if his pensionable income is higher his total earning career may be substantially shorter than that of the general practitioner. For the doctor who fails to ohtain a consultant post a career in the hospital service carries a lower professional status, with remuneration below that of the average general practitioner; and the longer he remains in hospital practice the more difficult it becomes to transfer to any other form of practice.

13. A career in general practice involves no long period of postgraduate training in hospital, and no higher academic qualifications are necessary for entrance or advancement. The usual method of entry into general practice is by an assistantship with an established practitioner, but many doctors experience considerable difficulty in proceeding beyond this stage and becoming estahlished as principals. Initially the income of a doctor in general practice may be higher than he would receive in the hospital service at the same age, but prospects of advancement are limited and the ultimate income is usually lower than that of the successful consultant.

14. University teaching and research appointments carry a high professional status and provide many advantages not enjoyed in the National Health Service, but the salary levels are lower than those of corresponding hospital appointments. Few graduates have Public Health, Regional Hospital Board, Government, or other administrative appointments as their primary aim immediately after registration. Many of the entrants have served previously in, for example, the Army or the Overseas Civil Service. Others have deviated, impatient and exasperated hy hospital practice, or hecause they are unable to wait longer for a consultant appointment or an opening in general practice. With a few exceptions, these appointments offer lower remuneration than hospital practice. Industrial medicine now offers comparatively few openings. After the war many new appointments were made and so there is a high incidence of holders of such posts in low age groups, with few prospective vacancies for many years, and few new appointments being made. So low is the demand that the University of Edinburgh no longer provides a course or a diploma in Industrial Medicine.

POSTGRADUATE STUDY

15. The doctor who aspires to a career in the hospital service, with a consultant appointment as his objective, must be prepared for a long apprenticeship. Apart from the regular study required to increase his knowledge and experience, special consideration has to be given to the acquisition of higher qualifications. Every consultant must hold a higher qualification of one of the Royal Colleges and/or Universities. No appointment is made in the major specialties unless this condition has been fulfilled, and in almost every case it is an essential hefore appointment to the post of senior registrar. Many registrars also hold higher qualifications.

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16. In general medicine the Membership of a Royal College of Physicians is the recognized qualification, in surgery the Fellowship of a Royal College of Surgeons, or alternatively a University Doctorate in Medicine or Mastership in Surgery, or the Fellowship of the Royal Faculty of Physicians and Surgeons of Glasgow. In obstetrics the Membership of the Royal College of Obstetricians and Gynaecologists is required, and in addition most consultants possess the Fellowship of a Royal College of Surgeons. In some specialties a diploma of the appropriate Faculty is required; for example, the Fellowship of the Faculty of Anaesthetists or of the Faculty of Radiology. These must be held in addition to specialist diplomas such as a Diploma in Anaesthetics or in Radiology. In general, no consultant appointment is made unless the applicant holds one or more higher qualifications in his specialty.

17. The examinations for these higher qualifications, though not competitive, are of a high standard and in general medicine and surgery the pass rate is less than one-third. In surgery the candidates for the F.R.C.S. have to pass a primary as well as a final examination.

18. It is difficult for a man to obtain higher qualifications while working in hospital. A separate period of study, during which no money is earned, is often required. This includes not only intensive reading, but also a large measure of practical and clinical work; and organized courses for the entrants to these examinations are expensive. For instance, apart from the time consumed, the approximate cost to a man who passes the primary and final F.R.C.S. examinations at the first attempt (and this is unusual) is about £140 for courses and £20 for the examination entrance fees. Because of the short tenure of junior hospital appointments, leave of absence except for a few days is not granted, and a man aiming at higher qualifications has to be prepared to support himself until he has passed the examinations and can compete for a registrar or senior registrar post.

19. It is not in the interest of anyone in the registrar or senior registrar grades to be too strictly confined to his own unit or hospital. To widen his experience he should have opportunities to study work elsewhere. He should thus be encouraged to visit other units, to take part in discussions at meetings, and to undertake original work or study. The rotation of senior registrars between central and peripheral hospitals is an important step in the training and in the dissemination of knowledge between one hospital and another. This may lead to disruption of family life and a number of difficulties encountered in moving, and hospital authorities should endeavour to minimize these problems to a far greater extent than at present by removal grants and the provision of married quarters.

20. Postgraduate study does not cease when consultant rank is reached. Continued reading of current literature and attendance at meetings are essential. It is at professional meetings that contacts are established and experiences exchanged; indeed, the discussions between individuals are sometimes more valuable than the subject-matter of the formal papers. Every consultant should be encouraged to take some part in the meetings of his specialist body, and it is a justified grievance of whole-time consultants that they are refused income-tax relief for subscriptions to these organizations and to the scientific publications.

21. Every hospital should maintain an adequate library or source of reference for its staff. This particularly applies to provincial or peripheral hospitals where the staff do not have ready access to medical libraries. At present the grants made to Hospital Management Committees by Regional Hospital Boards for this purpose are inadequate and the libraries of few hospitals are satisfactory. The majority of medical periodicals and books essential for the maintenance of professional standards have to be purchased by the individual.

22. Study leave is provided for in the Terms and Conditions of Service of hospital medical staff, but the present arrangements work very unevenly as between different hospital authorities. The main purpose of study leave is to facilitate attendance at special courses or meetings and the visitation of other hospitals in this country or abroad so that the staff may keep their knowledge and experience up to date. Study leave may be granted (1) with pay and with expenses; (2) with pay and without expenses; (3) without pay and without expenses. Hospital Boards have adopted

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differing policies in dealing with applications for study leave and in a number of instances have been unsympathetic.

23. At the commencement of the Service the Ministry placed a limitation upon the total amount which Boards might (within their approved budgets) grant annually as expenses in connexion with study leave. Thus the Oxford and Cambridge Boards were allowed to expend up to £1,200 annually; the Newcastle, Leeds, Sheffield, Liverpool, South-Western, and Welsh Boards up to £1,600; and the Metropolitan, Manchester, and Birmingham Boards up to £2,000. In the case of the Boards of Governors of teaching hospitals the maximum to he allocated as expenses varied hetween £800 and £1,200. In 1954 the Ministry abolished these limits, at the same time indicating that it did not expect that they would normally be exceeded. The Joint Committee has no doubt that the maximum sums to he used as study leave expenses were far from generous even in 1948. The indications are that the total amount actually granted as expenses is well below the maximum originally allowed hy the Ministry, and this is understandable in view of the many competing claims on the limited finances of Hospital Boards. In the opinion of the Committee a specific allocation should be made for this purpose.

24. During the past year the Central Consultants and Specialists Committee has made a detailed examination of the study-leave arrangements, and its comments and recommendations, which are endorsed hy the Joint Committee, are set out as an appendix to this memorandum.

DIFFICULTIES ENCOUNTERED BY MEMBERS OF THE REGISTRAR GRADES

25. In the early years of the Service there was an excessive trend to hospital practice induced by a high intake of ex-Service "trainees" and hy the anticipated expansion of the consultant service. The number of consultants in the less well-developed specialties has in fact increased, but there has been no great increase in consultant appointments in the main clinical branches, so that the junior grades in these branches have increased out of proportion to potential consultant vacancies. The excessive recruitment has now led to a falling off in the number of entrants to the hospital service. A higher proportion of those who might have become consultants in the future are now accepting appointments overseas or are being forced into other spheres of medical practice which initially they would not have chosen. Some of those who remain in the hospital service are transferring to other specialties, probably less attractive to them but offering better prospects of advancement. While this may not amount to an excessive resort to one hranch of medicine at the expense of another, it means that the less-favoured specialties are absorhing those who would have been an acquisition to the main clinical hranches.

26. The greatest difficulty facing doctors in the registrar grades at present is that of advancement to a settled and satisfactory career in the hospital service, or, failing that, in some other hranch of medicine.

27. Many registrars and senior registrars are married, often with young children. For at least six years, and often much longer, they have to subsist on a salary which in many cases is insufficient, and their financial difficulty, coupled with their lack of security, causes grave anxiety. Many registrars and senior registrars are required to be resident in the hospital and, as most hospitals cannot offer married quarters, have to maintain a home as well as paying for hospital board and lodging. An increase in the salaries of these two grades is urgently needed.

28. Attention needs to be given also to the career prospects in these grades. Senior registrars are too numerous, in relation to the number of consultants, to have reasonable prospects of a consultant career, particularly in general medicine, general surgery, and ohstetrics and gynaecology. In many branches there is a need for more consultant posts, especially in the non-teaching hospitals, and for a more efficient planning of the consultant service. This would result in a proportionate reduction in the number of senior registrars, particularly where they are undertaking duties which should he performed hy consultants.

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29. Steps should be taken also to facilitate the entry of hospital junior medical staff, including registrars, into general practice. Before the introduction of the Service it was considered a worthwhile preparation for tbe young doctor who intended to enter general practice to spend a few years in hospital appointments. Indeed, doctors with such experience were regarded with favour by established general practitioners seeking partners or assistants. This was partly a result of the greater opportunities which existed before 1948 for general practitioners to become part-time specialists and the consequent attractions to a principal of a young assistant or partner wbo was likely because of his qualifications and experience to enhance the standing of the practice by obtaining a hospital appointment.

30. Since the introduction of the National Health Service, however, tbere bas been no incentive for the prospective general practitioner to extend his hospital experience beyond the compulsory pre-registration period. On the contrary, the difficulties connected with settlement in general practice tend to encourage the young doctor to spend as little time as possible in the bospital service. This affects adversely the recruitment of hospital junior staff. In many bospitals it is proving extremely difficult to obtain sufficient junior staff.

31. Clearly, tbe quality of general practice would be enhanced by the entry of doctors with a wide basic training in hospital work, and the termination of national service will provide an opportunity for young doctors to spend a longer period in hospital appointments without feeling that they are delaying too long the start of their ultimate professional career. It will be necessary, however, to increase the salary of post-registration appointments if doctors are to be attracted to bospital work. A greater use in hospitals of the part-time services of suitably qualified and experienced general practitioners would also act as an inducement to the young doctor to extend his hospital training at the beginning of his professional life. The Joint Committee feels strongly that the present methods of recruitment to general practice should be examined closely with a view to making it easier for the doctor who has worked for several years in hospital to transfer to this hranch of medical work.

EMIGRATION

32. The profession has always had its share of those who have been attracted to seek a livelibood overseas, and in times past tbere bave been excellent opportunities for medical graduates from tbe United Kingdom to settle in the younger countries of the Commonwealth. In recent years, bowever, the Dominion countries especially have so developed that medical men from tbis country face mucb keener competition in settling in tbem. Despite the cbanged circumstances a number of doctors, often among the most promising, frustrated in their attempts to obtain consultant appointments in the United Kingdom or dissatisfied with conditions of service at bome, have emigrated since the introduction of the N.H.S.

33. What is more alarming is the high proportion of medical students wbo are attracted by tbe prospects overseas in comparison with those available in this country. A survey of student opinion conducted in the University of Edinburgh early in 1957 showed tbat only 36·5 per cent. of the medical students expressed a preference for work in Great Britain; 31 per cent. considered work overseas desirable; and approximately one-third were so undecided about their future prospects that they were unable to express an opinion.

34. The fact that so many members of the profession are driven to emigrate reflects dissatisfaction with the present conditions of medical practice in the United Kingdom. When tbis dissatisfaction spreads—as it is spreading—to students still in training for the medical profession, it bodes ill for future recruitment.

THE RELATIVE ADVANTAGES AND DISADVANTAGES OF DIFFERENT FORMS OF SERVICE

35. For the most part all junior grades of hospital medical staff are employed on a whole-time basis, the exception usually being where the practitioner is simultaneously engaged in general practice, or in research. Employment in tbe bospital service as a consultant or S.H.M.O., however, may be on a whole-time or part-time

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basis, and the majority of consultants and many S.H.M.O.s are engaged on a part-time basis, devoting the remainder of their time to private practice.

The Whole-time Consultant

36. The whole-time consultant receives the salary of the grade as laid down in the Terms and Conditions of Service, and certain additional payments agreed as a result of past negotiations between the profession and the Ministry of Health, or in Committee B of the Medical Whitley Council. He enjoys certain financial advantages in that he avoids the heavy overhead expenses of consultant private practice and the higher cost of living that is often unavoidable for a part-time consultant. He is somewhat better off than his predecessor in the local authority hospital service in that he is permitted to receive certain fees for professional services not regarded as coming within the scope of the National Health Service Act. These will be found listed in paragraph 14 of the Terms and Conditions of Service for Hospital Medical Staff. After performing eight free domiciliary consultations per quarter, the whole-time consultant is paid for any additional consultations up to an annual maximum of 800 guineas. He also enjoys the advantage of a comparatively regular professional existence, free from the unpredictable stresses of private practice.

37. His main financial disadvantages appear to be two in number. First, he is not paid—as an addition to his salary—the expenses "necessarily and reasonably incurred" in the course of his work, as listed in paragraph 16 of the Spens Report on the Remuneration of Consultants. Negotiations on this matter have been fruitless, and in the view of the Joint Committee the Spens Report has never been implemented in this respect. Secondly, he is not given by the Inland Revenue adequate and just allowances for the professional expenses inevitable in the holding of his appointment. Possibly the most important of these is an allowance for car expenses, including depreciation in car value. It is wholly unreasonable to say that a car is anything but an absolute necessity to a whole-time consultant.

38. The great disadvantage of the whole-time consultant's position is that he lacks the sense of professional independence that is felt by a consultant not wholly dependent upon his salaried appointment.

The Consultant with a Maximum Part-time Contract

39. This type of consultant is probably the most numerous within the Service. His financial advantages are, in the main, twofold. He is free to practise privately outside the hours that he gives to his hospital work. The volume of private consulting practice has undoubtedly shrunk greatly since the introduction of the Service, but varies much between specialty and specialty, between one part of the country and another, and between one consultant and other. Broadly speaking it is undoubtedly true of the maximum part-time consultant that he is mainly dependent upon his hospital salary. He enjoys, however, a measure of professional independence. His second financial advantage is that, certainly up to the present time, he has been more justly treated by the Inland Revenue in connexion with the allowance of professional expenses than has his whole-time colleague. There has been a recent adverse change in this regard with the transfer to Schdule E of many part-time consultants as far as their hospital salaries are concerned.

40. The part-time consultant suffers in the same way as his whole-time colleague from the failure of the authorities to make payments additional to his hospital salary for professional expenses that he necessarily and reasonably incurs. He enjoys the additional payments under paragraph 14 of the Terms and Conditions of Service and payment for all domiciliary consultations up to the agreed maximum of 800 guineas per annum.

41. Tbe advantages, both financial and non-financial, of the maximum part-time consultant are such that the great majority of consultants—over 70 per cent.—prefer this status.

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The Part-time Consultant with Only a Few Sessions

42. Unless a consultant is willing and able to work continuously exceptionally long hours there is necessarily a limit to the amount of private practice he can undertake if he is engaged on a maximum part-time basis in the Service. Some of the part-time consultants with only a few sessions are senior men who are well-established and successful in private practice and wish to devote most of their time to this. These consultants are comparatively few in number and are confined to the densely populated areas. It is probably a great advantage to medicine and to the public well-being that there should be this variation between consultants in the amount of time they apportion to their private work. It is desirable that there should remain a certain number of consultants who are primarily independent professional men, living by private practice. These consultants have the whole of their incomes assessed under Schedule D, and it is to be hoped that the courts will uphold the Special Commissioners' decision that all part-time consultants should be so treated.

43. Another group of part-time consultants with only a few sessions consists of young, recently appointed men who have failed to obtain a greater number of consultant sessions. This group presents a real problem because, as they have little or no private practice, their hospital income is insufficient to maintain them. Hospital Boards find it increasingly difficult to fill vacancies with fewer than eight sessions, and many Boards strive to advertise a new post or posts with sufficient sessions to provide an adequate livelihood. One method of dealing with this problem would be to pay a rate of remuneration higher than the normal rate as permitted under paragraph 5 (e) of the Terms and Conditions of Service, this being one of the purposes for which the provision was made by the Ministry.

The Senior Hospital Medical Officer

44. Where the holder of one of these posts has undertaken a full consultant training and has acquired the higher professional qualifications of the consultant, he usually, and with justification, feels himself underpaid if he finds himself in an S.H.M.O. post doing work of consultant quality and responsibility. The Royal Commission has already been informed of a recent decision of Committee B of the Medical Whitley Council to review certain S.H.M.O. posts in which the holders are considered to be doing consultant work, in order to decide whether they should be paid at consultant rates.

45. The S.H.M.O. enjoys the same security of tenure in his appointment as the consultant. The remuneration received suffers, as in the case of consultants, in that it has had in recent years inadequate adjustment to the cost of living. The 1954 increases granted to hospital staff were maximum in their benefit to the young consultant without a merit award. The S.H.M.O. did not benefit proportionately, and there is throughout the grade great dissatisfaction regarding status, prospects, and remuneration. It would be to the benefit of the Service if the S.H.M.O. grade were to be treated as a declining one.

COMPARATIVE TREATMENT OF WHOLE-TIME AND PART-TIME CONSULTANTS FOR INCOME-TAX PURPOSES

46. Reference has been made to the distinction in the matter of income-tax assessment as between whole-time and part-time consultants, and this merits further explanation.

47. Consultants employed on a whole-time basis in the Service are assessed for income-tax purposes under Schedule E. Relief from tax in respect of expenses, under this Schedule, is governed by the rule that if the taxpayer is necessarily obliged to incur and defray out of the emoluments of the employment the expense of travelling, or otherwise to expend money "wholly, exclusively, and necessarily" in the performance of his duties, such expenses may be deducted from the taxable emoluments, but not otherwise. This rule is extremely restrictive and in practice means that the taxpayer is unlikely to succeed in claiming any expense which he is not required to incur and defray out of his remuneration as a condition of his employment. Moreover, where, in the case of car expenses, for example, rates of

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mileage allowance or negotiated in the Whitley Council, no tax relief is allowed even though the doctor may be able to demonstrate that his expenses are greater than the allowance paid by his hospital board.

48. The expense of maintaining a telephone, subscriptions to learned societies, the cost of textbooks and periodicals, and the expense of attending professional meetings are not normally allowed to rank for tax relief in the case of a whole-time consultant assessed under Schedule E.

49. The Royal Commission on Taxation of Profits and Incomes commented in its Report on the position of professional persons in salaried employment, and recommended that the Schedule E rule should be amended in order to permit relief from tax in respect of expenses " reasonably incurred for the appropriate performance of the duties of the employment." If this recommendation was adopted by the Government it would go a long way towards meeting the present grievances of whole-time consultants in this matter.

50. Private consulting practice income is assessed under Schedule D, and the relevant rule governing expenses provides that no sum shall be deducted in respect of any expense not being money wholly and exclusively expended for the purpose of the profession. In practice the rule means that the rent, rates, and upkeep of professional premises, the wages of secretaries and receptionists, car and telephone expenses, subscriptions to professional bodies, and purchase of textbooks are all allowed. When the expenditure appears to confer some benefit on the taxpayer, however, objection is sometimes raised. For example, the cost of attending conferences or visiting hospitals, particularly those in other countries, is often disputed by the tax inspector for this reason.

51. At first sight it would appear that the part-time consultant is more favourably treated than his whole-time colleague in that for certain professional expenses which are common to both he alone can obtain tax relief. While this may have been true in the past, the position is somewhat different to-day. In recent years the Revenue authorities have tended to assess under Schedule E the hospital income of part-time consultants where this represents the major part of the professional income. One result of this is that tax inspectors are making a more searching examination of the expenses of private consulting practice, and often will not allow the full amount of expenses which they contend are not exclusive to the private practice. In some cases expenditure which the part-time consultant (but not the whole-time consultant) incurs (such as the salary of a secretary) is whittled down by the tax inspector on the ground that some of the work of the secretary is related to the National Health Service. This may well be true, because the part-time consultant may have to use his own secretary for some of his hospital work, and he is contacted at home and at his consulting-room in respect of public patients. But if the expense is not allowed in full because of this, he is in fact subsidizing the Health Service.

52. There is, of course, another approach to the question of expenses which, in the case of whole-time salaried employment particularly, would appear to be more appropriate than tax relief; that is, the payment of the expenses by the employing authority.

53. The Consultant Spens Committee stated that it presumed that the Inland Revenue Authorities would be prepared to consider favourably as legitimate allowances for income-tax purposes any items of expense which had been approved by a public hospital authority. This presumption has not been justified. The Spens Committee, however, also recommended that all specialists engaged either whole-time or part-time in the Service should be paid, in addition to their remuneration, any sums representing expenses necessarily and reasonably incurred in the course of their work. In the view of the Joint Consultants Committee this recommendation has never been satisfactorily implemented.

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THE INCENTIVES OF PRIVATE CONSULTING PRACTICE

54. In order to understand the importance of private consulting practice it is necessary to trace its history during the present century. The kind of doctor who does nothing but consulting work is tbe product of a number of factors. At the beginning of the century be did not exist outside London and a few very large provincial towns, and even there his work differed from what it is now. A provincial town of 100,000 or 200,000 inhabitants could not support consultants who did notbing else. The local consulting work was therefore done by a few senior or specially qualified general practitioners who comprised the staff of the local hospital. Their hospital work, historically derived from charitable institutions, was unpaid. Its out-patient work was often supplemented by independent dispensaries, also staffed by experienced general practitioners. The general practitioner consultant pbysician or surgeon naturally could not give as much time to his general practice as the general practitioners who did no consulting work, but he attended a smaller number of families and often had one or two partners who were wbolly engaged in general practice. Local consultants were supplemented when necessary by consultants from London or the nearest large centre.

55. Even in London in 1900, Harley Street and similar consulting centres did not exist. Consultants who staffed the teaching and other hospitals, unpaid, like their provincial colleagues, often had a consulting-room in the City where they were consulted by patients who lived in the suburbs and worked in London, and where they also acted as consultants to the insurance companies, as many still do.

56. As medicine became more complex and specialized, areas like Harley Street grew up in London and the large centres, where specialists were in easy reach of each other, and of nursing-homes and hospitals. Until the first world war, bowever, ancillary diagnostic aids were few and elementary. The enormous expansion of these since 1919 has, first in the United States and then here, tended to bring the consultant's consulting-room into or near his hospital, since many diagnostic and therapeutic methods are available only there.

57. Since 1948 the National Health Service has aimed at making a consultant service available throughout the country, and the general practitioner consultant has virtually disappeared.

58. It may perhaps be thought that in such circumstances private consulting work is valueless and unnecessary, and that the needs of the community could be met, and the desires of consultants satisfied, without it. That is far from the case.

59. Many consultants feel that the disappearance of private consulting work, which would make consultants solely dependent upon the State for their remuneration, would expose Medicine and the individual patient to dangers of an excessive State control, of which symptoms are even now to be detected in the Health Service. While recognizing the important part which whole-time practice plays in the Health Service, the Committee believes that the maintenance of private consulting practice is in the interest of the public welfare, and that it indirectly helps to maintain conditions of freedom and independence, even for the whole-time consultant, which would be seriously endangered if private practice were to disappear.

60. The work of the average out-patient hospital clinic is such as to limit strictly the amount of time that the consultant can devote to each patient. In an ordinary medical or surgical clinic there will often be twenty or more new patients and at least as many old ones. These have to be seen by a consultant with help which may vary from a senior registrar or registrar to a house officer. Under the Health Service these numbers are to some extent swelled by patients who have already been fully investigated at other hospitals, but having been told that nothing more can be done for them, seek a second or perhaps a third opinion. To reduce the numbers attending would be to increase the waiting-list and the delay before tbe patient could be seen. In present circumstances, therefore, few consultants can devote as much time as they would wish to seeing a new patient at hospital. Private practice makes it possible to see patients at greater leisure,

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and hospital patients benefit indirectly from the experience in history-taking and examination gained in private practice. Moreover, there are many patients whose professional and business responsibilities involve devoting much time to advising them on many points of detail, which is quite impracticable in hospital practice, and what has been said about consultations in a consulting-room applies equally to the management of a case in a nursing-home or a private bed in a hospital.

61. The short historical review will have shown that during the present century the work of consultants has become progressively more highly specialized in its scope. There is a strong feeling among consultants that private consulting practice retains a breadth of human contact sometimes embracing several members, and sometimes several generations, of the same family, which, together with a more intimate knowledge of their personal affairs, makes a human contribution to consulting work which in fact has developed little, if at all, in hospital practice, and which many would maintain can never develop in the same way in a State-provided service.

62. The increasing complexity of modern diagnotic methods and the expense of the apparatus, together with the need for skilled assistants to carry out investigations, have made it impossible for any but the largest nursing-homes to provide facilities comparable with those of a hospital. Hence the increasing use made by consultants of hospital private beds. The Health Service Regulations dealing with private beds provide that where the costs of the private block cannot be separately calculated the charge for admission to a private bed shall be determined by estimating the average daily cost per in-patient and adding 15 per cent. for a private bed in a single room, 10 per cent. in a double-bedded room, and 5 per cent. in a multiple-bedded room. This procedure operates unfairly in several ways. For example, although the consultant's professional fees are controlled by regulation, the hospital bed charges reflect changes in the cost of living. Moreover, the bed charges are not necessarily related to the quality of the accommodation and service provided. For instance, if a hospital has to pay heavy damages as a result of losing an action for negligence, this puts up the charge for the private beds. A patient who occupies a private bed frees a bed in the public ward for another patient. Besides, he has already paid by means of contributions and through taxation for the use of a bed, if necessary, in that hospital. It seems unfair that because the bed occupied is in the private block an additional charge of 115 per cent., which is out of all proportion to the additional cost of running a private bed as compared with a public bed, should be levied upon the patient. The result is that the cost of a private bed is in few instances less than 20 guineas, and is sometimes as high as 40 guineas a week in some special hospitals. The popular demand for private beds is reflected in the surprisingly rapid expansion of provident schemes since the introduction of the Health Service, but these schemes are handicapped by the fact that, to provide full cover by meeting the exorbitant charges, they have to charge a premium which is beyond the means of many who would otherwise gladly avail themselves of this service. The Committee suggests that the fair and reasonable way to cover the cost of private hospital beds is to assess what it costs to run them over and above the cost of a public bed which the patient would otherwise occupy. It would simplify matters if a flat rate were charged for comparable accommodation throughout the country. The effect would be to enable an increasing number of people to obtain the private bed accommodation they desire, under the consultant of their choice, to encourage private practice, and to make a financial contribution to the running of the Health Service.

63. The possibility of adding to his income by private practice provides an important incentive to the consultant. The value of such incentives is already recognized in the Health Service in the system of merit awards. No one will deny that many whole-time consultants to whom whole-time work particularly appeals do their best work without the incentive of private practice. But all men are not alike and there are those to whom the rewards of private practice are a direct encouragement to do, and continue to do, the best work of which they are capable.

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64. To sum up, then, the Committee would urge that private consulting practice makes a distinctive contribution to medicine which indirectly benefits the Health Service and is a means of attracting to medicine some of the most successful practitioners who, without opportunities for private practice, might well decide to seek their fortunes elsewhere.

DOMICILIARY CONSULTATION FEES

65. The Minister has an obligation under the N.H.S. Act to provide the services of specialists in the patient's home where necessary on medical grounds. Because the need for such domiciliary consultation or treatment would not be uniformly distributed as between different specialties, and because of the very considerable additional burden which such work might involve, the Spens Committee recommended that additional remuneration should accrue in respect of domiciliary work.

66. The Ministry adopted this recommendation of the Spens Committee, and the Terms and Conditions of Service introduced in 1949 included provision for the payment of the following fees:

> Fee for consultation, 4 guineas with an additional fee of (1) 2 guineas where any operative procedure other than obstetric is undertaken or where the officer uses his own electrocardiograph or portable X-ray apparatus; (2) 4 guineas for an obstetric operation; the additional fee of 2 guineas or 4 guineas to be payable once only in respect of each patient for the current illness.
>
> An additional fee of 1 guinea is also payable for a journey to a place over 20 and up to 40 road miles distant, 2 guineas for a journey to a place over 40 and up to 60 road miles distant, and so on with an additional guinea for every 20 miles.
>
> The maximum remuneration (excluding travelling and subsistence allowances, additional mileage payments, and fees for the use of the oonsultant's own apparatus) is fixed at 200 guineas in any quarter or 800 guineas in any year, at the consultant's choice.

67. Subsequently it was agreed that where a consultant called in for a domiciliary consultation saw more than one patient on the same occasion and in the same residence, the consultation fee should be 4 guineas for the first case, and 2 guineas for each subsequent case, up to a maximum of 10 guineas.

68. In November, 1955, it was agreed in Committee B of the Medical Whitley Council that whole-time consultants should be entitled to domiciliary consultation fees for all visits after the first eight in any one quarter.

69. The foregoing fees have never been adjusted to take account of the fall in the value of money, and the Committee recommends that they should now be increased by 60 per cent., with a corresponding increase in the yearly maximum remuneration.

70. The Committee is also strongly of the opinion that the obligation of the whole-time consultant to perform eight domiciliary consultations per quarter without payment is unfair, and should be abolished. When the service was introduced Hospital Boards were advised by the Ministry that where whole-time consultants were required to undertake domiciliary consultations their duties should be so adjusted that this would throw no extra burden upon them. In practice the Committee understands that it has been impossible to make such an adjustment of duties, and the whole-time consultant who carries out domiciliary consultations does so as an addition to his normal duties.

SPECIAL DISTINCTION AWARDS

71. The Consultant Spens Committee expressed the view that specialists of the highest eminence should be able, in the public service, to aspire to a remuneration of the order of £5,000 (in terms of the 1939 value of money). It recommended, however, that above a certain level remuneration should be determined on the basis of personal merit, and with this objective it proposed a basic salary range,

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together with a system of "special distinction awards." The intention of the Spens Committee was that 4 per cent. of all consultants should receive the highest award of £2,500 a year, a further 10 per cent. the next award of £1,500, and a further 20 per cent. the lowest award of £500 in addition to their basic salary.

72. The Minister adopted this proposal of the Spens Committee and since the beginning of the Service it is believed that special distinction awards have been made to the extent recommended. In other words, approximately one-third of consultants receive a total remuneration in excess of the basic salary scale.

73. The awards have been made, as recommended, on the advice of a predominantly professional advisory committee, which obtains its information regarding the merits of individual consultants in a variety of ways. Its Chairman and Vice-Chairman spend two or three months each year travelling round England and Wales in order to gain personal knowledge of the consultants in different areas. In addition, it seeks advice from the Royal Colleges and specialist organizations, from Hospital Boards, and from selected advisers in all parts of the country. A special Scottish Subcommittee makes recommendations to the national advisory committee regarding awards to consultants in Scotland.

74. The confidential nature of these awards has been an essential part of the system, and not unnaturally this has evoked some criticism. The Committee believes that the underlying principle of rewarding the outstanding consultant on the basis of personal merit is sound; that this offers an essential incentive to consultant work; and that the present method is better than any of the alternatives.

75. The suggestion has been that the monies allotted in the form of distinction awards should be used to extend the basic salary scale. The effect would be to narrow the total remuneration range recommended by the Spens Committee. This proposal has little support among consultants. Another suggestion is that additional remuneration should be attached to certain posts (rather than to certain individuals) in the form of "responsibility payments." In this way certain posts, as heads of departments or services at specified hospitals, would be paid at a higher level. The Joint Committee can see little if any merit in this proposal.

76. At the inception of the Health Service no adjustment was made to the distinction awards recommended by the Spens Committee in order to bring them into line with the 1948 value of money. The basic salary scale for consultants, as recommended by the Spens Committee in terms of the value of money in 1939, was increased at the maximum by 10 per cent., the Spens figure of £2,500 becoming £2,750, but no corresponding addition was made to the value of the distinction awards.

77. In 1954, the consultant basic salary scale was increased by £400 at the minimum and by £350 at the maximum point in the scale. The maximum became £3,100—an incease of 24 per cent. over the original Spens figure of £2,500. Again, no addition was made to the value of the distinction awards. On the contrary, for those holding A or B awards (i.e., those of £2,500 and £1,500) the new basic salary scale was "abated" by £300 and £200 respectively, which meant that, in effect, the value of these awards was actually reduced. On this occasion the Spens "weighting" formula used in the calculation of remuneration for part-time services was also modified. This, coupled with the abatement referred to above, had the effect of reducing the total remuneration of the holders of A and B awards performing between four and seven sessions. The consultants already in this category were accordingly allowed to retain their old level of remuneration.

78. In 1954 the profession had no opportunity of negotiating an increase in the distinction awards. It was a question of "taking or leaving" what was offered by the Government, and no real negotiations took place. The Joint Committee considers that it is contrary to the interests of the Service that the differentials within the consultant grade should be narrowed progressively as a result of periodical increases in the basic salary scale without corresponding adjustments of the distinction awards. Unless the differentials envisaged by the Spens Committee are maintained, there will inevitably be in the long run an adverse effect on the standard of recruitment to the hospital service, since the financial attractions of the

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service will be by no means comparable with those of other professions and occupations. For this reason the Joint Committee considers it important that the distinction awards should be increased in the same proportion as the basic salary scale at its maximum. The figure now claimed at the maximum of the basic scale is approximately £4,000, which is an increase of 60 per cent over the 1939 figure of £2,500 recommended by the Spens Committee. The Joint Committee therefore strongly recommends that each of the three distinction awards should be increased by 60 per cent. The values of the awards would then be £4,000, £2,400, and £800.

THE CONSULTANT'S LIABILITY FOR COMMITTEE WORK

79. The amount of time which a consultant in the Health Service requires to spend on committees varies greatly according to his seniority and responsibilities. The consultant who has no additional responsibilities beyond his work will need to attend the meetings of the Medical Committee of his Teaching Hospital or Hospital Management Committee, which would normally meet once a month or every two months. But even he is likely to find himself on several subcommittees, which also meet regularly; he will probably be appointed from time to time as a member of an advisory appointments committee, and he may also be a member of the Advisory Subcommittee of his Regional Hospital Board which deals with his special field of work. If he should be elected Chairman or Secretary of any of these bodies his work is at once greatly increased, for he would normally attend all subcommittee meetings and would find himself representing his committee at joint meetings with other committees concerned with common matters.

80. Members of the consultant staffs of Teaching Hospitals are, in virtue of their position, responsible for much of the work of the associated medical college. Though this is not strictly the work of the Health Service, its importance is recognized by the position of the Teaching Hospitals in the Health Service Act. Those members of the Teaching Hospital Staffs who are appointed to Boards of Governors and Academic Boards of Medical Colleges find their committee work at least doubled, and members of the staffs of Teaching Hospitals in general provide a high proportion of members of advisory appointments committees. The work is exacting and time-consuming, since it often involves travelling long distances, and it is sometimes difficult for the authorities who have to nominate the members of these committees to find sufficient suitable consultants who can devote the necessary time to it. Up to one-fifth of the membership of Boards of Governors consists of consultants nominated by the medical and dental teaching staff of the hospital, and normally upwards of 25 per cent of the members of Regional Hospital Boards and Hospital Management Committees consists of medical practitioners appointed after consultation with the profession.

81. A considerable amount of advisory work is done by consultants on committees of Regional Hospital Boards. The Joint Consultants Committee has always recognized the importance of this and desires that it should be further developed. There are medical members of the Boards themselves, and members of the Boards' main Medical Advisory Committees, of numerous subcommittees of both, and of special committees to advise the Boards on the organization of the various specialties. The North-East Metropolitan Regional Hospital Board, for example, has over 20 such specialist advisory committees. A comparatively small number of consultants who are already doing a good deal of work on Teaching Hospital and Regional Board Committees are elected by their colleagues to negotiate with the Ministry in connexion with the running of the Health Service—e.g., in the Joint Consultants Committee and Whitley Committee B.

82. Finally, exceptional duties which are only occasional, but are apt to be time-consuming, arise from the obligation to appoint consultants to Appeal Tribunals or special enquiries set up by the Ministries. Thus the committee work of consultants ranges from a minimum of perhaps two or three committees a month through that of Chairmen and Secretaries of important hospital committees, who may have several a week, to busy medical members of Regional Boards and committees of the whole profession whose committees are not only more frequent but last longer, often for a whole day at a time.

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83. Part-time consultants take their full share of such committee work, much of which is undertaken outside their sessional time. It is unpaid except to the extent provided for by the "weighting" formula used in calculating the salaries of part-time consultants. This weighting was reduced in 1954 despite the fact that the volume of committee work has greatly increased since the introduotion of the Health Service and is essential to its welfare.

SUPERANNUATION

84. Under the National Health Service Superannuation Scheme there are two methods of calculating pension for doctors employed in the Service. The pension of the general practitioner and part-time consultant or Senior Hospital Medical Officer is calculated by taking 1½ per cent. of the *total remuneration during the whole period of contributory service* (up to a maximum of 45 years). The pension of a whole-time officer, however (including the whole-time consultant or S.H.M.O.), is calculated differently. For each year of contributory service, up to a maximum of 45, the practitioner receives as pension 1/80th of his average remuneration over the final three years of service. During the period of his career a practitioner might at different times be a whole-time and a part-time officer, and in these circumstances his pension would be aggregated by the use of the two methods.

85. Where a part-time consultant or S.H.M.O. is in contract for not less than nine notional half-days, he may apply to the Minister to direct that the alternative method—i.e., 80ths of average remuneration— shall be used to calculate his pension. Such a direction, if granted, has no retrospective effect.

86. Broadly, the two methods are designed to meet equitably the differing circumstances of whole-time and part-time service. In particular, the method of calculating the pension at 1½ per cent of the total remuneration over the whole period of service was intended to meet the position of the practitioner who reached his peak level of remuneration in middle life, easing off his commitments before eventual retirement. In these circumstances to base the pension on the income in the final years of service might be unfair. Unfortunately, the present inflationary trend, and the fact that a merit award is normally "earned" in later life, tend to counteract any benefit of the 1½ per cent method, and place those part-time consultants and S.H.M.O.s who together with general practitioners have their pensions assessed by this method in a very insecure position.

87. In addition, hospital medical staff, with a compulsory retiring age of 65, are unable to earn the maximum pension because they cannot complete 45 years of contributory service.

NEGOTIATING MACHINERY

88. The Whitley machinery established for the conduct of negotiations regarding terms and conditions of service has proved itself completely unsuitable for dealing with major questions, and in many respects unsatisfactory for matters of lesser importance.

89. Decisions in Whitley are reached by agreement between the Staff and Management Sides, but while in theory this offers a safeguard to staff against downward alterations in the terms of service, in practice it presents great difficulty in pressing for improvements which involve large sums of money. The Management Side members have not the final authority to reach a settlement, and this necessarily induces a sense of frustration in the Staff Side. There is no right of appeal when an impasse is reached, arbitration being possible only by mutual oonsent. The fact that on two occasions the Staff Side of Committee B of the Medical Whitley Council (which deals with hospital medical staff remuneration) has had to by-pass the Whitley machinery and approach the Minister direct illustrates the inherent weakness of the system.

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90. Although theoretically the Management Side in Whitley consists of the representatives of the various employing bodies, in actual fact the proceedings are largely dominated directly by the Ministry and indirectly by the Treasury. At times so great has the influence of the Ministry been that the impression has been gained that proposals are not considered on their merits but rather from the point of view of the impact that they may have upon the economic situation generally. The Minister, as the ultimate employer and paymaster, has through his officers on the Management Side the opportunity of influencing the course of negotiation to a large degree, whilst reserving to himself the power of subsequent veto. This state of affairs must inevitably prejudice negotiations in Whitley from the start.

91. Theoretically, Whitley machinery should provide the means whereby both sides state their case and, by a process of give and take, reach a solution which is acceptable to both. In practice, and particularly on major issues involving finance negotiation in the true sense of the word does not occur. Indeed, it is obvious from such discussions as have taken place that the Management Side has agreed to a particular line of action prior to meeting the Staff Side and, without further private consultation, has felt unable to retreat from the position it has taken up. Thus the proceedings take the form of an offer or claim being made by the one side and its rejection or acceptance by the other.

92. The Whitley arrangements place the Minister in a most advantageous position. Whilst, through his officers, he continues to exert a very full measure of control over the discussions and decisions reached in Whitley, he can when challenged in Parliament on any particular issue resort to the comfortable reply that it would be inappropriate for him to comment upon, or in any way prejudice, discussions which are going on in Whitley. In effect the Minister enjoys the best of both worlds, and Whitley provides him with a convenient screen for resisting pay claims and for giving effect to whatever he considers to be the right solution to a particular problem.

93. If the course of Whitley could be directed towards negotiations in the accepted sense of the term it might quickly become a more useful channel for settling disputes of a minor nature. There are, however, strong arguments in support of direct negotiation when major matters of finance or other questions of national importance are involved.

94. To sum up, the Committee considers that there is a place for Whitleyism as a mechanism for negotiating terms and conditions of service, particularly those of a minor character, but that if the Whitley machinery is to continue it should be drastically overhauled. In particular the Committee would recommend that the Management Side should be composed of Government officers—of the Ministry of Health and the Treasury—with real authority to negotiate with the Staff Side.

95. In addition the Committee recommends that there should be set up a small advisory committee of eminent lay persons appointed by the Prime Minister in consultation with the profession, to keep under continuous review the general level of remuneration of doctors engaged in the National Health Service in order to maintain their proper economic and social status in the community. This body should be charged with the continuing duty of tendering advice to the Government on its own initiative, but should also consider and present its findings upon issues specifically referred to it by the profession or by the Government; for example, after normal negotiations between the Government and the profession have broken down. In the event of a reference to the advisory committee both parties should have the right to present a case and to be represented at the hearing.

96. The Committee would hope that normally the recommendations of such an advisory committee would be acceptable both to the Government and to the profession, though neither side could bind itself in advance to accept the findings of the advisory committee and both sides would have to reserve their right to freedom of action in the event of disagreement.

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SPECIAL CONSIDERATIONS AFFECTING MEDICAL REMUNERATION

97. In the foregoing paragraphs the Committee has endeavoured to deal with some of the matters on which the Royal Commission has specifically asked for information, and which in one way or another have a bearing on the question of the proper levels of remuneration of doctors engaged in the hospital and consultant services. In addition the Committee suggests that the following considerations are directly relevant to this question.

Length of Training

98. The period of training for a medical career in the hospital service is considerably longer and more exacting than that for most other occupations, and this must he taken into account in considering the financial rewards to he provided.

Lack of Security in the Early Years

99. The young doctor who aspires to become a consultant must he prepared to undergo the necessary training in hospital appointments of limited duration, ranging from six months to four years, appointments of over one year normally being renewed annually. He has no security until, normally hetween the ages of 32 and 40, he achieves the rank of consultant or S.H.M.O. He has to face the frequent movement of his home from place to place and often separation from his family for long periods. His chances of promotion are always problematical in the face of the keenest competition, and at any time he may find himself unahle to secure another hospital appointment. It is therefore essential to offer terms and conditions of service which are sufficiently attractive to induce young practitioners to accept the risks involved in seeking a consultant career.

CONCLUSIONS

100. In recommending levels of remuneration for consultants and other doctors engaged in the hospital service the Spens Committee had regard to the incomes which consultants had been able to earn under conditions of private practice. If the medical profession is to continue to attract candidates of the best quality it is essential that the financial rewards should be adequate, and the Committee considers that this would be achieved hy bringing the Spens levels of remuneration up to date.

101. As the Royal Commission will be aware from the claim suhmitted to the Government on behalf of the profession in 1956, the general practitioners regard the Danckwerts Award as having brought their remuneration, as determined by their Spens Committee, into line with the value of money in 1951.

102. In April, 1954, the salaries of hospital medical staffs were adjusted with the intention of restoring the balance of remuneration as between general practitioers and consultants which had heen disturbed hy the Danckwerts Award, and with certain qualifications the Committee accepts the 1954 adjustment as having brought the basic remuneration of hospital medical staff into line with that of general practitioners as at 1951. The Committee urges, therefore. that the salaries of hospital medical staff should now he further increased hy 29 per cent. to offset the fall in the value of money between 1951 and 1957, and to maintain the economic position of doctors in relation to other professions.

103. Consideration should also he given to the position of consultants holding distinction awards. As previously explained, the distinction awards still stand at the 1939 values recommended by the Spens Committee, no hetterment having heen added at any time, apart from the addition of 8 per cent. in the form of the Government's superannuation contrihution. The Committee is strongly of the opinion that these awards, which are an element of remuneration, and count for superannuation, should not be excluded from consideration in making such adjustments in remuneration as are deemed necessary hy changes in the value of money. The Committee therefore urges that the three distinction awards should now be increased hy 60 per cent. The Committee also recommends that the ahatement of the hasic salary applied to consultants with A and B distinction awards in 1954 should now be aholished.

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104. The effect of the Committee's recommendations is shown in the table below:

	Spens Scales	*Terms of Service* 1948	1954 *Award*	1957 *Interim Adjustment*	*Scales Recommended*
Consultant with "A" Distinction Award.	£4,000–£5,000	£4,200–£5,250	£4,300–£5,300	£4,405–£5,455	£6,709–£7,999
Consultant with "B" Distinction Award.	£3,000–£4,000	£3,200–£4,250	£3,400–£4,400	£3,505–£4,555	£5,109–£6,399
Consultant with "C" Distinction Award.	£2,000–£3,000	£2,200–£3,250	£2,600–£3,600	£2,705–£3,755	£3,509–£4,799
Consultant on basic scale.	£1,500–£2,500	£1,700–£2,750	£2,100–£3,100	£2,205–£3,255	£2,709–£3,999
S.H.M.O.	—	£1,300–£1,750	£1,575–£2,025	£1,653 15s.–£2,126 15s.	£2,031 15s.–£2,612 5s.
Senior Registrar ...	£900–£1,200	£1,000–£1,300	£1,100–£1,400	£1,210–£1,540	£1,419–£1,806
Registrar	£700–£800	£775–£890	£850–£965	£935–£1,061 10s.	£1,096 10s.–£1,244 17s. 6d
J.H.M.O.	—	£700–£1,000	£775–£1,075	£852 10s.–£1,182 10s.	£999 15s.–£1,386 15s.
Senior House Officer...	£600	£670	£745	£819 10s.	£950
House Officer ...	—	£350	£425	£467 10s.	Pre-reg. £550
		£400	£475	£522 10s.	2nd yr. £650–£700
		£450	£525	£577 10s.	

(The foregoing scales are for whole-time employment)

March, 1958.

APPENDIX

MEMORANDUM BY THE CENTRAL CONSULTANTS AND SPECIALISTS COMMITTEE UPON THE QUESTION OF STUDY LEAVE

1. Although individual considerations must always be involved in every application for study leave, a regional survey of study leave conditions has revealed differences in the practice of granting leave and expenses so great as to result in substantial injustices, and to call for an attempt to obtain agreement with the Ministry of Health on more uniform and equitable standards.

2. The Committee regards study leave as being applicable to Consultants, S.H.M.O.s, Senior Registrars, Registrars, and J.H.M.O.s, whole or part-time.

3. In R.H.B.(50)49, H.M.C.(50)48, B.G.(50)43 (hereafter referred to as R.H.B.(50)49, a copy of which is included in the Sub-Appendix to this memorandum) advice was offered by the Ministry to boards to help them in adjudicating on applications for study leave, and of the factors they were advised to take into consideration. Similar advice was given by the Department of Health for Scotland in R.H.B.(S)(51)3. The first and the most emphasized was "the possible advantage to the National Health Service generally, and the board's own specialist services in particular, of granting the application."

4. It must be accepted that one purpose of study leave is to foster professional knowledge and skill from which the patient will certainly obtain benefit, and if the patient, then presumably the National Health Service and the board's services also. But this result is an indirect one and ought not to be placed as the primary consideration in granting study leave—or to be used possibly as a basis for refusal to wbich no very satisfactory reply is possible on the part of the applicant (even if he knows that objection has been raised!). To make this principle so prominent is to infringe an important principle of the Spens Report and to sap the scientific status of the consultant profession which the Spens Report was seeking to uphold.

5. Study leave is essentially a provision made in the interests of the patient for maintaining the scientific position of the doctor and must not be regarded as baving any other professional purpose. Lay members of boards and committees, unfamiliar with this essential medical need and, therefore, possibly sceptical as to the purpose and value of study leave, must be made aware of its importance.

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6. The need for discussion of medical ideas and practice began to he apparent to the leaders of the profession as soon as the body of scientific developments began to form in the second half of the 19th century. Specialist societies hegan to be founded and were, in general, selective in membership so that the time available for meetings might be used most economically. Though excellent medical journals existed then, it was recognized that they did not alone serve all the needs of professional inter-communication, and regional, national and later international societies were established for this purpose. It is universally accepted in the profession that the meetings of these perform an important—even essential—service to medical progress and that to deprive any member of intermediate and senior hospital medical staff of the opportunity to attend regularly such meetings as are appropriate in his specialty is to inflict an irreparable professional injury. For this reason *the Committee recommends the rejection* of paragraph 3 (e) of R.H.B.(50)49 which states that among the factors to he taken into consideration when dealing with applications for study leave are " the opportunities, or lack of opportunities, of the applicant to keep abreast of his subject apart from study leave." It is appreciated, however, that in practice some restraint on the *universal* granting of study leave may be necessary.

7. Though, in practice, some restraint on the granting of study leave may occasionally be necessary, in order to maintain a fully adequate service, it is the view of the Committee that the principle which should be applied should be that study leave is granted whenever possible, and that boards should expect all members of their medical staff (except the house officers) to apply for study leave with some frequency, even to the point of prompting those who appear reluctant to do so.

Thus boards will be helping effectively to combat the small hut real danger of medical isolation and stagnation in their services.

8. Paragraph (6) of R.H.B.(50)49 reads as follows:

> " 6. When practitioners take an active part in scientific or clinical conferences or meetings of societies by holding office, reading papers or giving demonstrations, sympathetic consideration should be given to requests for grants towards expenses. Members of most scientific societies which meet regularly are able to choose the meeting at which they will present a paper or demonstration, and it should often be possible for them to select (with regard to time and place) the meeting which can be attended with the least inconvenience and expense to the service."

9. This introduces conceptions of study leave expense grants which hy their implications are in the view of the Committee too restrictive.

10. It is, in general, the meetings where the greatest expenses are involved that should call for the most liberal allowance of expenses. This is, of course, especially true of the meetings of international conferences abroad. The Committee considers that expense grants should not be limited to those who are to hold office, read papers or give demonstrations at medical meetings. Obviously the claims of these are most cogent, but valuable contributions are often made during the course of discussion by others attending meetings, and all who attend receive benefit whether they contribute or not.

11. Another group of medical staff which has to meet heavy expenses includes those who work in distant peripheral areas such as Northern Scotland and Northern Ireland and who may be debarred from attending meetings if they must meet the total expenses themselves. In regard to expenses generally, the needs of junior officers should receive special sympathy.

12. The Committee is of the opinion that the annual sums at present made available for study leave expenses are insufficient, especially in view of the considerable fall in the value of money since 1948 and the increase of senior medical staff and senior registrars, and boards should be advised to make substantially greater sums available for the purpose (at least double the sums originally allocated (before H.M.(54)28)). Where the total of permitted expenses claimed for study leave exceeds this annual allocated sum, each claimant should receive such proportion of his total annual claims as will reduce the total of all expense grants to the annual sum allocated, with resulting fairness to all concerned. This arrangement also obviates the penalizing of those whose applications are made late in the financial year when a fixed fund might have heen exhausted. Where such reduction has to be made, a

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statement of the gross overall claims and the percentage reduction should be issued to claimants at the time of payment.

13. The Committee would draw special attention to the need for study leave for members of the medical staff of small hospitals which are geographically remote. In para. (4) of R.H.B.(50)49 their special need for study leave is emphasized. Often the difficulty which makes granting of leave to them almost impossible at present is that no deputy is available. The Committee therefore recommends that the Ministry should be asked to advise boards to keep an adequate list of locum consultants and S.H.M.O.s who could be called upon to act under these conditions. It would be manifest injustice to compel the consultant or S.H.M.O. concerned to pay the locum himself or forego his own pay. Proportionately greater sums for expenses are needed in these remote areas.

14. The Committee recommends that applications for study leave should always be first considered by a medical committee appointed for the purpose by the board. In para. (5) of R.H.B.(50)49 boards are informed that they should seek the advice of their medical committees. This wise and obviously necessary procedure still does not obtain in some areas.

15. There is a widespread feeling that sometimes some study leave advisory committees, including some medical ones, exercise their function without a full regard to the basic equality of opportunity which should be offered to all senior medical staff to enjoy the privilege of study leave. Priority considerations are said to be based on personal prestige or other irrelevant criteria, so that the granting of leave with pay (with or without expenses) is very unevenly distributed. While the Committee thinks that such a state of affairs must be exceptional it is clear that study leave advisory medical committees ought to have a membership representative of all grades of staffs concerned with study leave.

16. The Committee has already commented on certain paragraphs of R.H.B. (50)49 and wishes to make the following additional observations:

(i) Paragraph 3a advises boards and committees when considering applications for study leave to take into consideration "the suitability of the applicant to benefit from the proposed leave." It is suggested that the Ministry should be asked to define the word "suitability."

(ii) Paragraph 3d advises boards and committees when considering applications for study leave to take into consideration "the number of applications from the region or hospital for any particular course or meeting." It is suggested that the Ministry should be asked to add the words "should not be limited except to ensure efficient maintenance of the Service."

(iii) The last sentence of paragraph 5 reads as follows: "consequently there will need to be discrimination not only between individual applicants but also between courses or conferences of a similar nature." It is suggested that it should be amended to read as follows: "There will *sometimes* need to be discrimination . . . in order to maintain the efficiency of the Service."

(iv) Paragraph 8 reads as follows: "Where a society holds regular one or two day meetings, it may be necessary to apportion leave periods to ensure that all officers who are members of the society are given facilities to attend a reasonable proportion of meetings, should they so desire." It is suggested that the following phrase should be added to this paragraph: "provided that permission to attend should not be withheld except to ensure the maintenance of an efficient service."

(v) Paragraph 9—third sentence reads as follows: "While giving due weight to the advantages to be gained from meeting colleagues abroad either socially or professionally, boards should be satisfied, before granting leave with pay in these cases, that the object of the visit is serious planned study from which the National Health Service will derive benefit." The emphasis should be on the knowledge and experience gained, and it is therefore suggested that the latter part of the sentence should read as follows: "that the object of the visit is serious planned study from which the National Health Service may be expected to derive benefit from the increased knowledge and skill of the staff concerned."

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FURTHER RECOMMENDATIONS

17. The Committee recommends that the general principles stated below should be adopted by hospital boards in dealing with applications for study leave, there being no discrimination as between whole-time and part-time officers. All applications should be considered by the medical advisory committee of the board suitably augmented by representatives of the grades concerned, or a similar *ad hoc* body, on which all categories of medical staff concerned should be represented. This Committee should make recommendations to the board, having regard to the suitability of the conference or study leave project.

(a) Leave for the Purpose of Taking an Examination

The Committee supports the practice commonly followed in connexion with leave for the purpose of taking examinations, namely, that examinees should be granted leave with pay but without expenses.

For many junior officers, especially those in small peripheral hospitals, a short intensive course of study may be both necessary and desirable before taking a higher examination, and, in view of the pressure and continuous work in such posts, may be the only practicable way in which instruction can be obtained. It is therefore recommended that paragraph 10 of R.H.B.(50)49 which states that if leave is granted for short intensive courses which have examination success as their sole aim it should be without pay, should be revised, and boards should consider such applications sympathetically with a view to granting study leave with pay.

(b) Leave for Examining

The Committee also supports the present practice in regard to leave for the purpose of examining—namely, that examiners should be granted leave with pay but without expenses.

(c) Leave of Short Duration for Attendance at Specialist Society Meetings

Leave with pay to attend conferences of short duration should be freely granted provided adequate arrangements can be made for the officer's duties to be covered during absence, bearing in mind the special difficulties of those who are isolated.

Travelling and subsistence allowances should also be granted according to the principles recommended above, and the granting of such expenses should not necessarily be related to the reading of papers at conferences.

(d) Leave of Longer Duration for Attendance at Conferences in Great Britain

Leave with pay should be granted for a period, or periods, up to a maximum of 18 days in one year or 30 days in two years, except in special circumstances when leave in excess of this might be granted by the board concerned. The question of expenses should be determined according to circumstances.

(e) Leave to Travel Abroad to Attend International Meetings or to Visit Hospitals

Leave with pay and expenses should be granted for a period, or periods, up to a maximum of 28 days in one year without any deduction being made from annual leave. Only in special circumstances should such leave be granted more than once in two years.

Under the present Terms and Conditions of Service, where leave is granted for a period in excess of three weeks, half of the excess is counted against the annual leave entitlement, and for this purpose an officer is allowed to carry forward from the immediately preceding year annual leave not exceeding three weeks. It is recommended that the Ministry should be approached with a view to extension of the present terms to enable officers to take longer periods of leave abroad. Officers might be entitled to carry on from year to year unexpended annual leave entitlement up to a maximum of 10 weeks to augment study leave allotment for purposes of a prolonged tour of foreign hospitals and medical clinics, etc., provided the board agrees and the standard of the hospital service is not thereby impaired.

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(f) Leave for Special Purposes

Where special leave is required for the purpose of complying with requests from the British Council, or other national bodies, the question of study leave, expenses, etc., should be determined on an *ad hoc* basis between the officer and the board concerned.

Locums for Officers Absent on Study Leave

18. On the question of locums to carry out the duties of those granted study leave, the Committee agrees with the present policy of employing authorities that the employment of a locum should not be necessary where the duties can be covered by colleagues during absence.

19. There is, however, a real problem in certain specialties and in certain areas where it is impracticable for the duties of the absentee to be covered by officers already employed by hospital boards. Where this applies officers may be denied any period of study leave, and it is often these to whom attendance at a conference or course is of the greatest value because the teaching centres are normally inaccessible to them. The Committee therefore recommends that, in such circumstances, employing authorities should engage a locum in order that the officer may be free for a period of study leave.

20. It is also recommended that hospital boards should maintain a register of those who would be available for locum duties of this nature.

Allocation of Expenses

21. In the early years of the National Health Service there were allocated to boards, for distribution annually, sums specially earmarked for payment of expenses in connexion with study leave. In 1954 this practice was discontinued. Since that time, it appears that boards have been unwilling to exceed the maximum previously allowed or even to equal it, in spite of the fact that the value of money has decreased. The Committee considers that the Ministry should be asked to make it clear to hospital boards that the original maxima should be at least doubled in view of the decreased value of money and the increase of medical personnel. It would seem practicable that each hospital board should earmark a sum of sufficient size to cover the study leave needs of the medical staff employed in the hospital service in the region, but as there is no fixed annual maximum applications for study leave with expenses should receive careful consideration at whatever time of the year they are made, and should not be related entirely to amounts already granted earlier in the financial year.

22. In some cases, where hospital boards do not defray travelling and subsistence expenses in full, it is recommended that for the benefit of those officers who are this involved in considerable personal expense, the Ministry of Health should be urged to seek an agreement with the Board of Inland Revenue whereby such expenses in connexion with study leave may be regarded as legitimate professional expenditure in respect of income-tax assessment.

SUB-APPENDIX

R.H.B.(50)49
H.M.C.(50)48
B.G.(50)43

HOSPITAL MEDICAL AND DENTAL STAFF

TERMS AND CONDITIONS OF SERVICE: STUDY LEAVE

1. This memorandum has been prepared to give guidance on the granting of study leave and to supplement the observations on the operation of the study leave scheme which were made in paragraphs 73 to 80 of R.H.B.(49)85, H.M.C.(49)70, B.G.(49)71. It is hoped that it will help boards to deal with applications for study leave, but it is not meant to be interpreted as a rigid set of instructions and does not presume to cover all possible types of application.

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2. The purposes for which study leave may be allowed are set out in paragraph 18 (d) (i) of the Terms and Conditions of Service; it cannot be claimed as a right, and while it is intended to be available to all grades of medical and dental officers at the discretion of the employing body the Department will not expect to find more than a few exceptional cases where it will be justified for House Officers, or, except in the circumstances referred to in paragraph 11 below, for Junior Registrars.

3. In dealing with applications for study leave, the board or committee and its medical advisory committee should take the following factors into consideration:

(*a*) the possible advantages to the National Health Service generally, and to the board's own specialist services in particular, of granting the application,

(*b*) the suitability of the applicant to benefit from the proposed leave,

(*c*) the nature and function of the course, meeting or conference for which leave is asked, e.g., scientific, clinical, medico-political, social or any combination of these activities,

(*d*) the number of applications from the region or hospital for any particular course or meeting,

(*e*) the opportunities, or lack of opportunities, of the applicant to keep abreast of his subject apart from study leave,

(*f*) the frequency of application of any one individual,

(*g*) the arrangement of deputies during the absence of officers,

(*h*) the views of other boards with whom the applicant is in contract.

4. Members of the staff of small hospitals which are geographically isolated find it more difficult to keep in touch with recent advances than do those in the regional centre. This isolation should be counteracted as far as possible by visits to and from senior members of staff and by meetings in the centre. It will, however, often be a factor in favour of study leave.

5. Boards will recognize that courses of instruction, scientific meetings, and conferences differ widely in the value of their contributions to medical science and to the educational advancement of those attending. It would be invidious to attempt any detailed differentiation in this document, and boards should seek the advice of their medical committees on the nature, purpose, and relative value of courses, etc. It has been the Department's view that study leave with pay will normally be justified for meetings of the specialist associations, but, generally, the status of the society or conference should not be the sole consideration and often not the primary consideration in deciding whether study leave should be granted; study leave is always subject to the exigencies of the service, and the other factors in paragraph 3 (particularly (*a*) and (*b*)) have to be given due weight. Consequently there will need to be discrimination not only between individual applicants but also between courses or conferences of a similar nature.

6. When practitioners take an active part in scientific or clinical conferences or meetings of societies by holding office, reading papers, or giving demonstrations, sympathetic consideration should be given to requests for grants towards expenses. Members of most scientific societies which meet regularly are able to choose the meeting at which they will present a paper or demonstration, and it should often be possible for them to select (with regard to time and place) the meeting which can be attended with the least inconvenience and expense to the service.

7. When medico-political or social activities are combined with scientific or clinical meetings and are likely to occupy a proportion of what may reasonably be considered to be "working hours," the allotment of study leave, if granted, should be related to the duration of the clinical and scientific activities; it is not unreasonable to expect the applicant to devote a part of his annual leave to that part of the period given over to other activities and to relaxation.

8. Where a society holds regular one or two day meetings, it may be necessary to apportion leave periods to ensure that all officers who are members of the society are given facilities to attend a reasonable proportion of meetings, should they so desire.

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9. A difficult problem is sometimes presented by individuals or unofficial groups who wish to make a tour of hospitals or clinics abroad. Before the introduction of the National Health Service these trips were usually undertaken at the traveller's own expense, and in part, at least, were looked upon as a relaxation; six weeks' annual leave with pay was not then available. While giving due weight to the advantages to be gained from meeting colleagues abroad either socially or professionally, boards should be satisfied, before granting leave with pay in these cases, that the object of the visit is serious planned study from which the National Health Service will derive benefit; and, as suggested in paragraph 7 above, it would not be unreasonable to expect the applicant to devote a fraction of his annual leave to any part of the period which is given over to relaxation.

10. Within the registrar grades (but not ordinarily during the first year as Junior Registrar) some applications may be received for leave to attend postgraduate courses of instruction. Courses organized on an educational basis will benefit both the individual and the National Health Service, and leave with pay will often be appropriate; but short intensive courses ("cram courses") which have examination success as their sole aim should not be included in this category, and if leave is granted it should be without pay.

11. Leave without pay for six months or occasionally a year may be granted to registrars wishing to take an academic or other paid appointment for the purpose of special study or research in a university department.

12. Applications for prolonged leave will occasionally be made by officers intending to work in a hospital or laboratory abroad. In these and in other cases of application for leave abroad, the board should be satisfied (*a*) that the applicant has had such training in this country as will enable him to profit by his experience abroad and to assess critically the value of what he learns, and (*b*) that he is, from all points of view, likely to maintain the prestige of British medicine abroad. In general, it is preferable that leave for the purpose of working in hospitals abroad should be sponsored by a recognized postgraduate or research organization or by a national or international body awarding Fellowships. The applicant should be at least of Senior Registrar status.

13. In some cases applications for prolonged leave may be made for the purpose of keeping alive superannuation rights. It should be borne in mind that prolonged leave is not the only method of preserving superannuation rights, as the Minister has power, under section 19 of the National Health Service Amendment Acts, 1949, to recognize work elsewhere than in National Health Service Hospitals in suitable cases as "approved" service for superannuation purposes.

14. In determining the allocation of expenses, it has to be remembered that the funds available for this purpose are not unlimited and that discrimination is unavoidable if they are to be used to the best advantage.

15. The Minister has discussed with the Joint Committee arrangements for the granting of leave to hospital medical staff for the purpose of examining, and it has been agreed that the Terms and Conditions of Service of Hospital Medical and Dental Staff should be amended as follows:

Paragraph 18 (d) (ii) (B) (c)

Insert at beginning of (c): "Except in the case of leave granted to officers in order to allow them to act as examiners in examinations held by universities or medical corporations for the purpose of granting medical or dental degrees or diplomas. . . ."

Ministry of Health,
Whitehall, S.W.1.

June 8, 1950.

94111/3/5.

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SUPPLEMENTARY MEMORANDUM OF EVIDENCE TO THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

Representatives of the Joint Committee gave oral evidence before the Royal Commission on the 18th December, and on that occasion the Commission put to the Committee's representatives a number of questions on which it wished to have further information.

The Committee has considered the various points raised by the Royal Commission, and its comments upon them are set out below:—

Q. References are to the Royal Commission's published Minutes of Evidence, Day 2.

A. Q. *354*

Question:

It would appear that since the beginning of the Health Service the number of consultants has increased while the number of general practitioners has remained relatively stationary. Has the Joint Committee any views as to the appropriate relative numbers of consultants and general practitioners ?

Comment:

(1) The Committee does not consider it practicable that the relative numbers of general practitioners and consultants should be determined in an arbitrary manner. Indeed, it does not believe that the appropriate numbers in each field are necessarily interdependent.

(2) It is not difficult, however, to account for the proportionately greater increase in the consultant field which has taken place in recent years. There has been a publicly organised general practitioner service, covering a substantial proportion of the community, since 1911. In addition to the National Health Insurance Scheme there were many local medical clubs (often organised by the general practitioners themselves) through which by a system of small weekly or monthly payments general medical treatment was made available to the wives and families of working class people. Long before 1948, therefore, the community as a whole had the benefit of a family doctor service, which paved the way for the introduction of the National Health Service in this field.

(3) As explained in the Committee's memorandum of evidence, the growth of consultant practice is a much more recent development.

(4) Before the Health Service consultants devoted a considerable proportion of their time, without payment, to the hospital treatment of the poorer classes, and they depended largely for their professional livelihood upon fees received for the treatment of wealthier people. This, of itself, necessarily limited the number of doctors who could make a financially successful career in consultant practice.

(5) Quite apart from the social change which has taken place, however, a more significant reason for the growth of consultant practice has been the advance in medicine and the introduction of new techniques in the past 20–25 years. Since 1939, and more particularly since 1948, hospitals in the smaller towns and country areas have developed into institutions providing a full range of consultant advice and treatment with all the necessary ancillary facilities. This has inevitably involved a substantial increase in the number of consultants, particularly in certain branches. One of the objects of the Health Service was the provision of a consultant service throughout Great Britain, and this has been substantially though not, in the opinion of the Committee, fully achieved.

B. Q. *380*

Question:

Page 64 of the Ministry's memorandum of evidence shows the trend in the establishment of registrars and senior registrars. Will the Joint Committee comment on this ?

(*Note:* The figures quoted in the Ministry's memorandum are as follows:—

	1951	*1952*	*1953*	*1954*	*1955*	*Increase or decrease*	
						No.	*Per cent.*
Senior Registrars ...	1,547	1,296	1,195	1,253	1,262	−285	−18·45
Registrars	1,856	2,111	2,259	2,446	2,620	+764	+41·2)

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Comment:

(6) The reduction which has taken place in the number of senior registrars since 1951 is the result of the Ministry's policy (agreed with the Joint Committee) to endeavour to relate the numbers of senior registrars in training for consultant posts to the number of anticipated consultant vacancies. This reduction has been made largely at the expense of non-teaching hospitals, and there is little reason to doubt that it accounts in part for the corresponding increase in registrar appointments in such hospitals.

(7) Despite the reduction in senior registrars there are still in certain specialties many more fully trained men than there are consultant vacancies. The Committee is firmly of the opinion that this, and the increase in registrar appointments, is due in large measure to the failure of Hospital Boards to create additional consultant posts which are needed. In short, these men are in many cases doing work which properly should be done by consultants, and if more consultants were appointed the numbers in the Senior Registrar and Registrar grades could be reduced with benefit to the Service and to the prospects of junior staff aspiring to a consultant career.

Q. *385–387*

Question:

Can the Joint Committee provide evidence as to the lack of candidates for registrar and senior registrar appointments (*a*) in general, (*b*) as between teaching and non-teaching hospitals, (*c*) in special hospitals?

Comment:

(8) The following views and figures have been obtained from the Senior Administrative Medical Officers of a number of Hospital Regions:—

NEWCASTLE:

"With regard to the recruitment of Registrars and Senior Registrars I am afraid that we are never overburdened with applications for regional appointments and in certain specialties such as Diagnostic Radiology, Orthopaedic Surgery, Radiotherapy and Pathology, we invariably fail to get any response. The three best specialties in the way of applications are Obstetrics and Gynaecology, General Surgery and General Medicine, but here again when Senior Registrar posts are advertised, we are very fortunate if we get more than two applications.

In this region we work in very close association with the Teaching Hospital and since the inception of the Registrar training scheme, we have held a Joint Committee every month and I think it is true to say that the Teaching Hospital has more or less the same problems as ourselves, but in certain specialties they sometimes receive slightly better applicants, but, of course, there are occasions when even they cannot recruit.

We are trying to overcome the difficulty by advertising appointments where the candidate is offered training not only in the Teaching Hospital, but in some of the larger hospitals in the Region where excellent material is available. Sometimes hospitals in the periphery are more successful in filling their vacancies because the clinical chief is able to contact some of his colleagues in other parts of the country."

SHEFFIELD:

(a) *Lack of candidates in Senior Registrar Appointments*

Senior Registrar appointments in this Region come mainly under two headings:

(i) Reciprocal posts with the teaching hospitals

(ii) Non-reciprocal posts which generally speaking relate to the regional specialties such as Chest Diseases, Psychiatry, Venereology and Radiotherapy.

(i) *Reciprocal posts with the teaching hospitals*

These posts cover the specialties of Anaesthetics, E.N.T., General Medicine, General Surgery, Obstetrics and Gynaecology, Pathology and Radiology.

Apart from Radiology, all appointments are filled but it has been observed that the number of applications are fewer and the quality of applicant is lower.

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For some time, Senior Registrar appointments in Radiology have been difficult to fill.

(ii) *Non-reciprocal posts*

In Chest Diseases, Orthopaedics and Venereology, all posts are filled but they have been filled for at least two years and therefore the Board has no up to date knowledge of the availability of suitable candidates.

The Board's one Radiotherapy post was last filled 12 months ago but there were only two applicants.

Senior Registrar appointments in Psychiatry have proved very difficult to fill and the Board has one vacancy at present.

(iii) The Regional Hospital Board has no Senior Registrar appointments in Plastic Surgery, Dental Surgery, Ophthalmology, Paediatrics, Neuro-Surgery and Dermatology; any information regarding these specialties should be sought from the Board of Governors, United Sheffield Hospitals.

(b) *Lack of candidates for Registrar Appointments*

Registrar appointments cannot be classified under the headings given. There are no joint appointments between teaching and non-teaching hospitals and generally speaking Registrars are appointed to one hospital although in some cases they provide assistance at a second hospital nearby.

Some Registrar posts seem always difficult to fill and these are analysed generally below. It is not easy to draw any definite conclusion from this analysis; some hospitals and some districts are obviously more attractive than others. Shortage of staff often leads to greater shortage because existing staff are often grossly overworked and leave.

Specialty	*Remarks*
Chest Diseases	Three of the Registrar appointments out of a total of nine seem to prove unattractive to applicants.
Obstetrics and Gynaecology	One post out of a total of sixteen seems to prove difficult. The fact that this post is not recognised for the M.R.C.O.G. possibly explains this.
Anaesthetics	There are fifteen Registrar posts in this specialty and a third of them are difficult to fill.
Neuro-surgery	There is only one post in the Region and this is rarely filled.
Orthopaedics	About a third of the fourteen posts in the Region prove difficult to fill.
Orthopaedics and Casualty	There are four Registrar posts where duties are shared between the orthopaedic and casualty departments and three of these are always difficult to fill.
Casualty	One of the Casualty registrar appointments out of a total of three proves difficult.
Thoracic Surgery	One of the four posts in the Region does not attract candidates.
Infectious Diseases ...	There is only one registrar post in this specialty (others are linked with Chest Diseases) and this always proves difficult.
Psychiatry	Registrar appointments in Psychiatry constantly cause trouble. If advertisement as Registrar proves unattractive, posts are often advertised in the J.H.M.O. grade.

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Apart from the number of applicants, it is interesting to note their nationalities and the following details give:—

(i) The nationalities of Registrars in post, and

(ii) An indication of the nationalities of applicants in Registrar posts.

N.B. During 1957 the Sheffeld Regional Hospital Board advertised 201 Registrar posts. Of these, no applications were received in 69 cases. The 388 applicants referred to in Section (ii) of the following table relate to 132 appointments.

Nationality	(i) Registrars in post in Sheffield Region on 15th November, 1957		(ii) Nationalities of applicants for Registrar posts during 1957	
	Number	Percentage	Number	Percentage
Australian	9	6·4	39	10
Bolivian	—	—	1	·3
Burmese	—	—	1	·3
Canadian	—	—	2	·5
Ceylonese	—	—	1	·3
Czechoslovakian	—	—	2	·5
Egyptian	1	·7	11	2·7
Greek	2	1·4	7	1·8
Hungarian	1	·7	2	·5
Indian	35	24·8	171	44·1
Iraqi	—	—	1	·3
Irish	13	9·3	14	3·6
Israeli	1	·7	—	—
Italian	1	·7	1	·3
Jordanian	—	—	1	·3
Maltese	1	·7	2	·5
New Zealand	5	3·6	8	2·1
Palestinian	1	·7	—	—
Pakistani	4	2·8	27	6·9
Persian	—	—	2	·5
Polish	4	2·8	7	1·8
South African	2	1·4	6	1·5
Spanish	1	·7	4	1·0
Turkish	—	—	1	·3
U.K. including Northern Ireland	57	40·5	73	18·8
Ukranian	1	·7	1	·3
West African	1	·7	—	—
West Indian	1	·7	3	·8
Totals	141	100	388	100

The following more recent analysis of the position in regard to hospital junior medical staff has since been received from the S.A.M.O. of the Sheffield Region:

1. *Nationality of Registrars*

For the purpose of this investigation, the nationalities have been divided into two groups as under:—

Group A	*Group B*
United Kingdom	All others
Australia	
Canada	
New Zealand	
South Africa	
America	

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(a) *Numbers in post*

On 28th April, 1958, the position in the Sheffield Region was as follows:—

	No. of Registrors in post
Group A	81
Group B	63*
Total	144

* The 63 registrars in Group B were divided between 14 different nationalities but the majority (45) were Indians or Pakistanis. A large number of those appointed possess temporary registration only.

(b) *Notionalities of applicants for Registrar posts*

The nationalities of applicants for registrar posts in the Sheffield Region during the year ending 31st March, 1958, have been analysed and are as follows:—

	No. of Applicants
Group A	128
Group B	250*
Total	378

* The 250 applicants in Group B were divided between 21 different nationalities but the majority (201) were Indians or Pakistanis.

Perhaps the figures given in para. 1 (*b*) indicate the nationality situation better than those in para. 1 (*a*). The 378 applications analysed relate to 191 registrar posts advertised so that the position was that there were only 128 Group A applicants for 191 posts. A further analysis would undoubtedly reveal:—

(i) that many of the 128 Group A applicants were for the same posts, i.e., the more attractive ones.

(ii) where there was only one Group A applicant on the short list, he was nearly always appointed.

(iii) many posts had no Group A applicants at all.

(c) *Analysis of individual posts*

(i) In 14 registrar posts, there has not been a Group A incumbent during the 3 years from 1st June, 1955.

(ii) Only 45 registrar posts out of a total of 113 have been staffed entirely by Group A in the 3 years from 1st June, 1955.

2. *Number of applicants for Registrar posts*

During the twelve months ended 31st March, 1958, the Board advertised a total of 191 Registrar posts; 378 applications were received; no applications at all were received for 66 of the appointments.

3. *Turnover of Registrors*

Other difficulties exist in addition to shortage of medical staff. The turnover of registrars is much greater than it should be as the following figures demonstrate:

*Analysis carried out over 3 years from 1st June, 1955** (*see note on following page*)

(*a*) 315 Registrars have occupied 113 posts.

(*b*) 4 Registrar posts (including 3 in General Surgery) have each had 5 different registrars during the three years.

(*c*) 16 Registrar posts (including 6 in General Surgery) have each had 4 different registrars during the three years.

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(*d*) 50 registrar posts (including 10 in General Surgery) have each had three different registrars during the three years.

(*e*) The turnover of registrars in the surgical specialties (particularly general surgery) has been extremely high during the three years in question:—

	No. of posts	*No. of Registrars who have occupied the posts*
E.N.T.	2	4
Obstetrics and Gynaecology	11	27
Gynaecology	1	4
†Ophthalmology	3	10
†General Surgery	22	75
†Thoracic Surgery	4	13
Casualty	3	8
Orthopaedics	10	30
Orthopaedic/Casualty	2	6
General Surgery/E.N.T.	1	3

† In these specialties, on average registrars remain in post less than a year.

(*f*) The following analysis of turnover of registrars by specialty is interesting:

	Under 6 months	6 to 12 months	12 to 18 months	18 to 24 months	Over 24 months	Total
Group A	22	79	35	35	22	193
Group B	24	66	18	9	5	122
Total	46	145	53	44	27	315

Those figures show that:—

(i) 60 per cent. of registrars appointed serve 12 months or less

(ii) 47 per cent. of Cat. "A" registrars continue beyond their first year.
26 per cent. of Cat. "B" registrars continue beyond their first year.

(iii) 29½ per cent. of Cat. "A" registrars continue beyond 18 months.
11½ per cent. of Cat. "B" registrars continue beyond 18 months.

* *N.B.* The period 1st June, 1955 to 31st May, 1958 has been analysed. It is possible, during the period of review, for a registrar to terminate his two year appointment say on 30th September, 1955, a registrar to complete a two year tenure 1st October, 1955 to 30th September, 1957 and another registrar to commence 1st October, 1957 and still be in post, i.e., three registrars to go through the post during the 3 year review each completing (or proceeding to complete) a normal 2 year tenure. This possibility was appreciated but it has been ascertained that it only applies to two registrar posts during the review period and therefore the figures quoted are not materially affected.

4. *Registrar Vacancies*

During the three years from 1st June, 1955, out of 113 posts:—

10 posts have been vacant for over 6 months
5 „ „ „ from 4 to 6 months
20 „ „ „ „ 2 to 4 months
16 „ „ „ „ 1 to 2 months

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5. *Pre-registration and S.H.O. vacancies*

There are three types of posts in this Region:—

Intern/S.H.O—S.H.Os. can only be appointed to these posts if all reasonable attempts to obtain a pre-registration student have failed.

S.H.O/Intern—The Hospital Management Committee can decide whether the post is filled by a S.H.O. or as pre-registration post.

S.H.O.— Must be filled by a S.H.O.—not recognised by the Licensing Authority for pre-registration purposes.

A check was made of the position on 28th April, 1958 and this was as follows:—

	No. on establishment	*No. in Post*	*Vacant*
Intern/S.H.O	83	42 Interns 32 S.H.Os.	9
S.H.O./Intern	34	27 S.H.Os. 4 Interns	3
S.H.O.	112	100	12
	229	205	24

The vacancies represent just over 10 per cent. of the total establishment and many Hospital Management Committees, when the review was made, emphasised such points as the difficulties which are constantly experienced in obtaining the most junior staff; posts can only be filled by foreign doctors, etc. Several appointments have been vacant over twelve months, some considerably longer.

6. *Senior Registrar Appointments*

It will be seen from question 4 (*b*) of Appendix B that the Board consider they can get Senior Registrars of the right quality with the exception of Senior Registrars in Psychiatry, Radiology and Radiotherapy.

The response to all advertisements for Senior Registrars since 1st January, 1954 has been analysed and the following facts are worthy of mention:

(a) *Radiology* ... ... 1 applicant on 6 occasions
2 applicants on 2 occasions
3 applicants on 1 occasion
9 appointments advertised.

(b) *Radiotherapy* ... ... 1 applicant on 1 occasion
2 applicants on 2 occasions
3 appointments advertised.

(c) *Psychiatry* ... ... 1 applicant on 9 occasions
2 applicants on 3 occasions
7 applicants on 1 occasion
13 appointments advertised.

(d) *General Medicine*

7 appointments have been advertised; the most applications ever received has been 7; the most recent advertisement only produced 4 applicants.

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(e) *General Surgery*

Whilst the number of applicants might still be regarded as adequate, the following figures show that the number is diminishing:—

	No. of applicants
1 Reciprocal post advertised in 1954	31
1 Reciprocal post advertised in 1955	22
1 Reciprocal post advertised in 1957	16
1 Reciprocal post advertised in 1958	16

NORTH WEST METROPOLITAN REGION:

"I am sending on the enclosed sheets particulars of (a) the senior registrar appointments made during 1957 and, in an attempt to give some comparison, similar appointments made during 1951. Close comparisons cannot be made, however, between the two years for certain reasons. One is that in 1951 there existed no interchange or joint appointments between regional board and teaching hospitals. I think it is clear, however, that the fields were larger in 1951 than they were in 1957. I enclose also (b) a summary of registrar appointments made during 1957 with corresponding information relating to 1951. The registrar establishment has been substantially expanded during the intervening years so the total number of appointments successfully made is not perhaps a fair comparison between the two years. What is revealing is the number of times certain posts have had to be readvertised on account of the poverty of the field and then, in a number of instances, no appointment could eventually be made."

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Senior Registrar Appointments during 1957

Group	W/T or P/T	Hospital	Specialty	Whether linked with a Teaching Hospital	No. of applications	No. short-listed	Whether appointment made
Windsor	P/T, 7/11	King Edward VII, Windsor.	Ophthalmology ...	No	5	2	Yes
Barnet	W/T	Clare Hall	Thoracic Surgery (Supernumerary).	No	10	4	Yes
	W/T	Group...	Anaesthetics ...	No	7 (1 withdrew)	4	Yes
Mid Herts ...	W/T	Herts Child Guidance	Psychiatry	No	4	3	Yes
	W/T	Hill End	Psychiatry	No	6	5	Yes
Hendon	W/T	Edgware General ...	Anaesthetics ...	No	5 (1 withdrew)	3	Yes
	W/T	Edgware General ...	Anaesthetics ...	No	2 (both withdrew)	—	No
	W/T	Edgware General ...	Anaesthetics ...	No	2 (1 withdrew)	1	No
Uxbridge ...	W/T	Hillingdon	Medicine	Interchange with Royal Free Hospital	7 (1 withdrew)	5	Yes
St. Bernards ...	W/T	St. Bernards	Psychiatry	No	8 (1 withdrew)	4	Yes
Harefield and Northwood.	W/T	Harefield	Medicine (Chest Diseases)	No	4 (1 withdrew)	3	Yes
S.W. Middlesex...	W/T	West Middlesex ...	E.N.T. Surgery ...	No	4 (1 withdrew)	3	Yes (This was a second attempt. Previously advertised unsuccessfully).

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SENIOR REGISTRAR APPOINTMENTS DURING 1951—*continued*

Group	Hospital	Specialty	No. of applicants	No. short-listed	Whether appointment made
Central Middlesex ...	Central Middlesex	Radiology	6 (1 withdrew)	3	Yes
	Willesden Chest Clinic	Chest Diseases	12	6	Yes
	Central Middlesex	Orthopaedics	4 (3 withdrew)	1	Yes
Archway	Archway Group Laboratory ...	Pathology	7 (1 withdrew)	3	Yes
	Whittington	Medicine and Neurology ...	4	3	Yes
	Whittington	Orthopaedics	1	1	Yes
	Whittington	Medicine...	6	5	Yes
	Whittington	Paediatrics	3	2	Yes
	Whittington	Obstetrics and Gynaecology ...	7 (2 withdrew)	3	Yes
Northern	Royal Northern	Anaesthetics	6	5	Yes
Paddington	National Temperance	Surgery	7 (2 withdrew)	4	Yes
	Tavistock Clinic	Psychiatry	2	2	Yes
Mid-Herts	Plastic Unit, Hill End	Plastic Surgery	11	5	Yes

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SUMMARY OF REGISTRAR APPOINTMENTS DURING 1957

(I) *Peripheral Hospitals*

Groups: Bedford, Luton and Hitchin, Mid-Herts, West-Herts, Staines, Windsor.

(*a*) Appointment made from a field of six or more applicants.

21 Posts filled:

General Medicine	10
General Surgery	7
Obstetrics and Gynaecology	2
Chest Diseases	1
Rheumatism	1

(*b*) Appointment made from a field of less than six applicants.

16 Posts filled:

General Surgery	4
Anaesthetics	3
Casualty	2
Orthopaedic	1
Geriatrics	1
Pathology	1
Chest Diseases	1
Obstetrics and Gynaecology	1
General Medicine	1
Paediatrics	1

(*c*) Posts not filled on first advertisement.

Re-advertised once and appointment then made:

St. Albans City	Casualty
Watford Peace Memorial	Radiology
Staines	Gynaecology
Hounslow	Chest Diseases
Maidenhead	Surgery
Maidenhead	Surgery
Upton	Anaesthetics

Re-advertised twice and appointment then made:

Watford Chest Clinic ... Chest Diseases

Appointment not made:

Luton and Dunstable ... Anaesthetics
Re-advertised twice without success.

Luton and Dunstable ... Paediatrics
Vacancy filled by senior house-officer.

West-Herts and St. Pauls ... Anaesthetics (Two Vacancies).
Re-advertised six times then only one vacancy filled.

Watford Hospitals ... Obstetrics and Gynaecology. (Locum engaged).

Windsor Chest Clinic ... Chest Diseases. (Locum engaged).

(II) *Central or Near Central Hospitals*

Groups: Barnet, Hendon, Uxbridge, Harefield and Northwood, S.W. Middlesex, Central Middlesex, Archway, Northern, Paddington and R.L.H.H.

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(*a*) Appointment made from a field of six or more applicants.

62 Posts filled:

General Surgery	19	
General Medicine	16	
Obstetrics and Gynaecology	10	
Paediatrics	4	
Psychiatry	3	(1 part time)
Pathology	3	
Anaesthetics	2	
Radiology	2	
Thoracic Surgery	1	
Ophthalmology	1	
Endocrinology	1	

(*b*) Appointment made from a field of less than six applicants.

39 Posts filled:

Anaesthetics	11	
Chest Diseases	7	
General Surgery	5	
Orthopaedics	2	
General Medicine	2	
Paediatrics	2	
Psychiatry	2	(1 part time)
Ophthalmology	1	
Neuro Surgery	1	
Pathology	1	
Obstetrics and Gynaecology	1	
Medicine (Hom.)	1	(part time)
Neurology	1	
E.N.T.	1	
Casualty	1	

(*c*) Posts not filled on first advertisement:

Re-advertised once and appointment then made:

Hendon Isolation	Medicine (I.D.)
Edgware General and Bushey	Obstetrics
Harefield	Chest Medicine
Harefield	Chest Medicine
Mount Vernon	Radiology
South Middlesex	Infectious Diseases
Central Middlesex	Anaesthetics

Re-advertised twice and appointment then made:

Uxbridge Chest Clinic	Chest Diseases
Finchley Chest Clinic	Chest Diseases

Re-advertised three times and appointment then made:

Colindale	Chest Medicine

Re-advertised five times and appointment then made:

Royal Northern	Radiology

No appointment made:

Edgware General	Anaesthetics

One vacancy re-advertised four times, and later two vacancies re-advertised once.

Colindale	Surgery

Re-advertised once—no applicants either time.

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Hillingdon, St. Johns etc. ... ... Geriatrics
Re-advertised once. (Second re-advertisement in 1958 successful).

Royal Northern ... ... Orthopaedic
Re-advertised twice.

Royal Northern ... ... Casualty
Unsuccessful advert. in 1957. Re-advertised twice in 1958 before appointment was made.

(III) *Psychiatric Registrars at Mental Hospitals*

9 Posts filled:

(Four cases where the field of applicants were six or more).

REGISTRAR APPOINTMENTS IN 1951

(I) *Peripheral Hospitals*

Groups: Bedford, Luton and Hitchin, Windsor, Mid-Herts, West-Herts, Staines.

(*a*) Appointment made from a field of six or more applicants.

3 Posts filled:

Anaesthetics	1
Rheumatism	1
Medicine	1

(*b*) Appointment made from a field of less than six applicants.

11 Posts filled:

Surgery	2
Medicine	2
Orthopaedics	2
Dental	1
Paediatrics	1
Obstetrics and Gynaecology	1
Chest Diseases	1
Pathology	1

(*c*) *No appointment made:*

Orthopaedics—Heatherwood.

One applicant only—appointed as locum for 3 months, and then a report from the consultant.

Chest Diseases—Windsor C. Cl.

Two applicants: one seen, post to be re-advertised.

(II) *Central or Near Central Hospitals*

Groups: Barnet, Hendon, Uxbridge, Harefield and Northwood, Central Middlesex, Archway, Northern, Paddington and R.L.H.H.

(*a*) Appointment made from a field of six or more applicants.

25 Posts filled:

Medicine	9
Obstetrics and Gynaecology	7
Anaesthetics	3
Psychiatry	3
Surgery	2
Radiology	1

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(*b*) Appointment made from a field of less than six applicants.

32 Posts filled:

Medicine	6	
Anaesthetics	3	
E.N.T.	3	
Radiology	3	
Chest Diseases	3	
Paediatrics	3	
Psychiatry	3	(2 part time)
Obstetrics and Gynaecology	2	
Thoracic Surgery	2	
Casualty	1	
Pathology	1	
Phys. Med.	1	
Orthopaedics	1	

(*c*) No cases where no appointment was made.

(III) *Psychiatric Registrars in Mental Hospitals*

7 Posts filled:

(One case where the field of applicants was six or more.)

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SOUTH EAST METROPOLITAN REGION

SENIOR REGISTRARS—SUMMARY OF APPOINTMENTS ADVERTISED, ETC.

Year				Central Hospitals			Peripheral Hospitals			Special Hospitals			
	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made	Remarks
1955 ...	7	49	1	—	— (see note 1)	—	1	12	—	6	37	1 (see note 2)	One appointment of Senior Registrar in Thoracic Surgery shown under special unit column
1956 ...	7	22	5	—	—	—	1	4	—	6	18	5	—
1957 ...	6	24	1	—	—	—	4	23	—	2	1	1	—

Notes:

1. The majority of the Senior Registrar appointments in Central Hospitals are joint appointments made with teaching hospitals, under the special interchange scheme. The teaching hospitals (Guy's, King's College and Maudsley) make arrangements for the appointments.
2. The appointments not made were for Senior Registrar (Psychiatry) posts in Regional hospitals.

REGISTRARS—SUMMARY OF APPOINTMENTS

Year	GENERAL TOTAL			CENTRAL HOSPITALS			PERIPHERAL HOSPITALS			SPECIAL HOSPITALS OR UNITS		
	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made
1955 ...	73	265	25	34	141	11	21	93	6	18	31	8
1956 ...	87	246	35	25	109	7	44	113	20	18	24	8
1957 ...	96	307	29	30	127	7	45	136	16	21	44	6

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SOUTH WESTERN:

"It is becoming more and more difficult to make suitable appointments in the Registrar and Senior Registrar grades. In the Registrar grade it sometimes happens that advertisements produce no applicant at all and, when advertisements do produce candidates, not infrequently they are unsuitable for appointment. Thus, compared with, say, five years ago, the applicants are fewer in number and, in some specialties, their quality is not as good as it was. Some excellent candidates from the Commonwealth seek appointments as Surgical Registrars and we are glad to give them every possible help.

The teaching hospital has the advantage over the non-teaching hospital because many Registrars and Senior Registrars have come to believe that they are unlikely ultimately to be appointed Consultants unless they have been trained in teaching hospitals. There is very little difference between the response which we receive to advertisements for trainee posts in central and peripheral hospitals, and, so far as special departments are concerned, the position is deplorable."

WELSH:

"The lack of candidates for registrar and senior registrar appointments has become more noticeable in recent years, and nowadays it is particularly difficult to recruit registrars for appointments in outlying hospitals. As you have placed these registrar posts in the various categories, I will deal with each in turn.

(*a*) As I have already stated the overall number of applicants competing for these trainee appointments has become less and less until it is quite a common occurrence to have to advertise an appointment on several occasions before we are successful in appointing a suitable candidate.

(*b*) The joint appointments which exist between a teaching and non-teaching hospital continue to yield one or two very good candidates, but, here again, there is considerable evidence of a reduction in the number of candidates competing for these appointments.

(*c*) As one would expect the central hospital has a considerable advantage over the peripheral hospital and our difficulties in filling registrar posts are inevitably increased when the vacancy exists at one of the outlying hospitals, which can well be a great distance from any main centre or the teaching hospitals which afford facilities for registrars at some of the regional hospitals in the immediate vicinity.

(*d*) There are certain recruitment difficulties which affect registrar appointments at special hospitals, but for the most part I would say that in our experience the functions of these hospitals are still sufficient to attract a candidate of the required standard."

LIVERPOOL:

"I would say that, in general, there is no lack of applicants for Senior Registrar posts except perhaps in certain specialties, such as Psychiatry and Radiotherapy, and I would qualify this statement by saying that, especially in Psychiatry, the applications we do receive are from doctors who do not really have sufficient experience in the specialty to qualify for appointment to a Senior Registrar post.

It is quite clear that there is a shortage of suitable candidates for Registrar posts, especially in E.N.T., Orthopaedic Surgery, Thoracic Medicine, Dentistry, Pathology and Radiotherapy. I feel that it would generally be found that the Teaching Hospitals will always have more applicants than the non-teaching hospitals and I am quite sure that this applies in the Liverpool region. The same situation does exist as between central and peripheral hospitals in Regional Board Hospitals. It is always difficult for us to obtain suitable applicants in most specialties in the peripheral areas.

To emphasise the lack of suitable candidates for the Regional Hospitals I would quote one instance where we advertised for a Registrar in General Surgery with the Professorial Unit at a central Regional Hospital and received 11 applications. All the applicants were of foreign nationality, 10 applications being received from Indians and one from an Austrian.

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		Number of Applicants	
		Teaching Hospital	*Peripheral Hospital*
Obstetrics and Gynaecology	1951	12	—
	1952	11	10
	1955	—	4
	1956	11	—
	1957	6	—
Ophthalmology	1952	4	—
	1953	5	—
	1955	3	—
	1956	3	—
	1957	2	—

Posts which have proved difficult to fill:

1. Reg. E.N.T.	Royal Inf. (T)	advertised	12 times	to date
2. Reg. Surg./Obst./Gyn. ...	Greenock Area	,,	10 ,,	,,
3. Reg. Pathology	Victoria Inf. (T)	,,	11 ,,	,,
4. Reg. Pathology	Dumfries	,,	8 ,,	
5. Reg. Surgery	R.A.I. Paisley	,,	9 ,,	
6. Reg. Pathology	Maternity (T)	,,	7 ,,	
7. Reg. Surgery	P. Glasgow	,,	9 ,,	
8. Reg. Psychiatry ...	Riccartsbar	,,	6 ,,	
9. Reg. Radiodiagnosis ...	Victoria (T)	,,	6 ,,	
10. Reg. Psychiatry... ...	Bellsdyke/R.S.N.I. ...	,,	5 ,,	to date
11. Reg. Surgery	Law	,,	5 ,,	,,
12. Reg. E.N.T.	Stobhill	,,	5 ,,	,,
1. Sen. Reg. Radiotherapy	Western Inf. (T)	,,	13 ,,	,,
2. Sen.Reg.Ophthalmology	Ophthalmic Inst.... ...	,,	4 ,,	,,
3. Sen. Reg. Ophthalmology	Eye Inf. (T)	,,	5 ,,	,,
4. Sen. Reg. Medicine ...	Hairmyres	,,	3 ,,	,,
5. Sen. Reg. Pathology ...	Southern General (T) ...	,,	4 ,,	,,
6. Sen. Reg. Plastic Surgery	Royal/Western (T) ...	,,	4 ,,	,,

((T) = Teaching Hospital)

Senior Registrars

In 1953 ... ... 31 posts were advertised
Of these 1 was a readvertisement

In 1957 ... ... 64 posts were advertised
Of these 38 were first advertisements
7 were second advertisements
19 were third or subsequent advertisements

The following comments have also been received from consultants on the staff of London teaching hospitals:—

Dr. Reginald Kelly:

" Thank you for your letter of 9th January. The question of the difficulty in obtaining Senior Registrars and Registrars is a matter in which my experience has been that what difficulty does exist is mainly concerned with the non-teaching hospitals. In the two teaching hospitals to which I am attached we have had no difficulty in recent years in finding adequate applicants for Registrar appointments in General Medicine and General Surgery. We have always had a choice of several applicants, all of whom have their Membership, and I do not know of any examples in recent years of worthwhile applicants failing to apply for Registrar posts because of financial difficulties. In the special departments of St. Thomas' Hospital, however, it has become plain in recent years that a decreasing number

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of doctors are prepared to apply for Registrar posts. In the Children's Department, for instance, recently we had only three applicants for a Senior Registrar appointment and we were unable to make an appointment because we felt that none of the three applicants were of sufficient merit. In the Neurological Department we have had no difficulty but that is because we encourage doctors to apply for our own Registrar post who are anxious to learn some Neurology before taking up General Medicine and only about one in three or four Registrars intends to take up Neurology as a career. At the Maida Vale Hospital, since I have been on the Staff there, we have always had a considerable number of good applicants, both for the Resident and the Registrar appointments, middle and Senior Registrars, and on those occasions when we have appointed overseas doctors, it was because we judged them to be the better applicant, rather than because there was any shortage of well trained and experienced British doctors applying for the jobs.

In non-teaching hospitals the position is entirely different. In the last eight years I have been connected with three large non-teaching hospitals, Queen Mary's Hospital for the East End, the Prince of Wales' Hospital at Stamford Hill and Mount Vernon Hospital at Northwood. In the first two of these three hospitals, the only applicants for the Registrar posts who have the Membership have been visiting doctors from the Dominion countries. It has become plain that any doctors who have any future in Consultant medicine refuse to apply for these appointments at non-teaching hospitals because experience has taught them that in spite of the special experience that they gain at these hospitals it is extremely difficult for them to get back to their teaching hospital in a Registrar or Senior Registrar appointment if they have spent a considerable period in a non-teaching hospital. Another disadvantage of working in non-teaching hospitals and of which these doctors are aware is the fact that there is a very large volume of routine work for them to do, far greater than they are called upon to do at a teaching hospital. It occupies a very large part of their ordinary working week and leaves little time for personal study, for attending post graduate courses or lectures, or for carrying out any original work. At Mount Vernon Hospital we have had rather less difficulty in obtaining good applicants for the Medical Registrar appointment, but this is purely and simply because Mount Vernon Hospital is in many ways an annexe to the Middlesex Hospital. A large number of the staff are on the Staff of the Middlesex Hospital and the applicants for the posts always come from the Middlesex Hospital with the certain knowledge that they stand a very good chance of being able to return to the Middlesex Hospital for their more senior appointments. I believe, myself, that one of the difficulties in filling these appointments at non-teaching hospitals is due to the fact that when the National Health Service came into being, the majority of these Registrar posts were down-graded and in the years immediately before the War at both the Prince of Wales' Hospital and Queen Mary's Hospital, it had been the custom for the Medical Registrar to be a doctor who had completed his training for Consultant appointments, who already had had his senior qualifications for some years and who was, in fact, waiting for a Consultant appointment. They were able to hold these jobs for a number of years and almost invariably left them for Consultant appointments. Dr. Carmichael Young, for instance, who is one of the Physicians at St. Mary's Hospital was Registrar at the Prince of Wales' Hospital until he received that appointment. It is undeniably an attraction to the candidate, who might apply for the appointment at a non-teaching hospital, if one or more of the Physicians are attached to a teaching hospital. Consequently those at non-teaching hospitals whose staff are concerned only with non-teaching hospitals have far greater difficulty than Mount Vernon Hospital has at the present moment or the Prince of Wales' Hospital had until I resigned from the Staff of that hospital a few weeks ago.

A point that I would like to make but not, perhaps, connected directly with our difficulties at the Maida Vale Hospital in appointing Registrars so much as dealing with the difficulties that we make for the applicants. Last week we were appointing an ordinary Registrar in Neurosurgery, jointly with the Maida Vale Hospital and the Middlesex. We had three excellent candidates with previous experience in Neurosurgery and with their Fellowships. Mr. Logue considered, quite obviously reasonably, that the successful applicant must have a car, as by the nature of his

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work be would be expected to travel quickly not only from one bospital to the other, but also wben called out, as he is likely to be called out several times a week, during the night. The successful applicant did not, in fact, have a car, and so it was pointed out to him that we would be unable to offer him the job unless he was prepared to get himself a car. This, in fact, be agreed to do, but I felt that it was quite iniquitous that we should find ourselves in the position of having to demand that a young man sbould buy a car and run it at his own expense on the comparatively low salary he was being offered for tbe job when we are, at the same time, not in a position to offer him the ordinary mileage allowance for daily use of the car that he would receive were be a part-time employee of the Service. He is a married man with two children and this requirement on our part that he should get a car is obviously going to place him in considerable financial difficulty unless be has a private income. He accepted this condition of service quite obviously because he wanted the job very badly, but it is plain that a doctor who is entirely dependant upon his salary would have found it quite impossible to accept the job under those circumstances."

" As you know I am on the staff of St. Thomas' Hospital and we bave in recent years received at least two requests from the Regional Hospital Boards which in themselves mirrored the difficulties tbat the Regional Hospitals have in filling their Senior Registrar posts with suitable applicants. We have, as many teaching hospitals in London have at the present moment, an arrangement with Southampton wbereby we make a joint appointment of a Senior Medical Registrar with the Southampton hospitals, which results in eacb of our four Senior Registrars spending one of their four years working in a Southampton Hospital Group. We were specifically asked to do this because of the difficulties they bave of getting suitable candidates. We bave recently been asked by the East Anglian Regional Board wbether we would be prepared to make the same arrangement with them, or an arrangement which is similar. The arrangement that they are asking for is that a Senior Registrar appointed to them sbould be allowed to be seconded for one year to work at St. Thomas' Hospital, because they feel that by doing this they may make their own Senior Registrar appointment more attractive and, therefore, perbaps get better applicants. It is not possible, obviously, for me to anticipate the decisions of our own Joint Medical Committee at St. Thomas' Hospital but it seems to me likely that at least many of my colleagues will be unwilling to continue the present arrangement we have with Portsmouth and Southampton and if that is so, it is clear that these Provincial Regional Hospital Boards will have greater difficulty in filling their appointments."

Dr. J. Hamilton Paterson:

" I hope the following information which I have culled from our records here will be of help to you in connection with the Royal Commission.

During the last three years there bave been 12 appointments to the resident staff of registrar and senior registrar grade (the resident medical officer is a senior registrar grade). The average number of applicants for these posts fell from six in 1955 to three last year. Six of the successful candidates were from the United Kingdom—six were from Overseas. Over the same period there were seven vacancies for senior registrar appointments to the Out-patient department. On two occasions no appointment was made and it is of note that last year there was only one applicant on one occasion and none at all on the other when such a vacancy arose. Similarly, four registrar grade appointments in the Out-patient department have been advertised over the same period, although on one occasion the post was not filled through lack of a suitable applicant. All the registrars wbo have been appointed to the Out-patient department have come from the United Kingdom.

In sbort, we have not as yet experienced much difficulty in obtaining suitable resident bouse pbysicians, although the number of applicants has steadily fallen in recent years. In tbe Out-patient department, however, we have latterly had very considerable difficulty in filling our vacant registrar and senior registrar posts. I sbould add that this information does not include surgical appointments. There are never many candidates for these posts."

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D. *Q.* 388

Question:

Will the Joint Committee comment on any differences in staffing between teaching hospitals and non-teaching hospitals, especially peripheral hospitals?

Comment:

(9) In general, teaching hospitals are more heavily staffed than non-teaching bospitals both in the senior and junior grades of medical staff. This is necessary to meet the needs of teaching and research in addition to the care and treatment of patients. In addition it is the normal practice in the clinical departments of teaching bospitals for consultants to work in " firms "; i.e. a senior and junior consultant (*both* of full consultant status) dividing the consultant work between them and sharing junior staff. This system is not so common in non-teaching bospitals, wbere consultants tend to work independently.

(10) The majority of senior registrars are employed in teaching hospitals, where better and, in some instances, the only facilities for training exist. In many cases there are arrangements for these senior registrars to spend part of their time in non-teaching bospitals, but a great many non-teaching hospitals, particularly the smaller ones, do not have senior registrars.

(11) As will be seen from the comment on Question 3 above, there is usually more difficulty in filling junior vacancies in Regional Hospitals tban in teaching bospitals. It is undoubtedly true that appointments in teaching hospitals bave always proved attractive because of the great advantage whicb a teaching hospital training confers on tbe aspirant for a consultant post. At the present time, bowever, registrars and senior registrars wbo hope to make their career in consultant practice tend actively to avoid non-teaching hospital appointments in the belief that such appointments will bandicap tbem in the competitive struggle for promotion.

(12) Another reason for the sbortage of junior staff in non-teaching bospitals is that bospital experience is no longer regarded as increasing a young doctor's prospects of entering general practice.

(13) Some outlying bospitals were able in past years to attract junior staff by offering them a higher rate of remuneration than did the teaching and larger non-teaching hospitals. Except to a very limited extent this is not possible under the Health Service.

(14) The inadequate staffing of many non-teaching and peripheral bospitals makes cover during periods of annual leave more difficult to arrange and throws a heavy burden on the medical staff in times of emergency.

E. *Q.* 431–432

Question:

There is evidence that the ratio of wbole-time and part-time consultants is changing. Is this good for the Healtb Service? Is there a minimum below whicb the wbole-time establisbment should not fall: What, in the opinion of the Joint Committee, is the appropriate ratio between whole-time and part-time consultants?

Comment:

(15) There would appear to be no evidence that any substantial cbange is taking place in the ratio between the numbers of whole-time and part-time consultants. The following figures for England and Wales provided by the Ministry some years ago show that in tbe early years of the Health Service there was a movement towards wbole-time employment.

	Total No. of Consultants	*Whole-time*	*Part-time*	*Percentage of whole-time to Total*
31st December, 1949 ...	5,189	1,309	3,880	24·4
31st December, 1950 ...	5,649	1,491	4,158	26·4
31st December, 1951 ...	5,882	1,650	4,232	28·1
31st December, 1952 ...	6,247	1,780	4,467	28·5

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(16) Figures obtained from four English Regions in respect of the years 1955–57 show a slight movement towards part-time employment:

Newcastle, Sheffield, Manchester and S.E. Metropolitan Regions

	Total No. of Consultants	*Whole-time*	*Part-time*	*Percentage of whole-time to Total*
1955	1,804	461	1,343	25·5
1956	1,828	447	1,381	24·4
1957	1,868	453	1,415	24·2

(17) In these four Regions 53 consultants changed from a whole-time to a maximum part-time basis in the three years 1955–57, and 2 maximum part-time consultants changed to a whole-time basis. In this period the total number of part-time appointments increased by 72, and the number of whole-time appointments dropped by 8. Allowing for these transfers from whole-time to part-time and *vice versa*, this means that 43 new whole-time posts were created, as against 21 part-time.

(18) The Joint Committee does not consider, however, that fluctuations in numbers of whole-time and part-time consultants of the kind illustrated above have any special significance. Certainly it could not accept the argument that it would be contrary to the good of the Health Service and the community to allow the number of whole-time consultants to fall below a certain level. As the Committee has previously stated, *all* consultants have a continuing responsibility for the patients under their care, and it would be completely false to assume that the whole-time consultant is indispensable. The great majority of part-time consultants are engaged for the maximum of nine sessions, and in practice it would be impossible to distinguish between the responsibilities in the Health Service of whole-time and maximum part-time consultants.

(19) At the outset of their careers a proportion of young consultants accept whole-time appointments as bringing a certain element of financial security, but when they become established in the area they may prefer the independence of private practice. This is particularly true in the main clinical branches, as opposed to branches such as, say, psychiatry or chest diseases, where there is a tradition of whole-time service.

(20) It should be pointed out, however, that when a whole-time consultant transfers to a maximum part-time basis he almost invariably gives his employing authority an undertaking to continue to fulfil all the duties of his appointment as hitherto, so that the Health Service does not lose by the transfer, but on the contrary makes a financial saving.

F. *Q. 494*

The Consultant Spens Committee recommended the present system of merit awards when there were 1,600 consultants. There are now 7,000. Does this alter the validity of their recommendation ?

Comment:

(21) The figure of 1,600 consultants referred to by the Royal Commission is presumably the number of consultants from whom Professor Bradford Hill obtained information when he made his enquiry into the pre-war earnings of consultants for the benefit of the Spens Committee.

(22) A classification of the profession carried out for the Central Medical War Committee in March, 1940, however, gave the total number of consultants and specialists at that time as 4,601. This figure includes those in Northern Ireland (not more than 100–150), but probably excludes a number of university teachers and research workers who were also working in hospitals as consultants.

(23) In the view of the Joint Committee there is nothing in the Spens Report to suggest that in putting forward its recommendations regarding distinction awards the Spens Committee was at all influenced by, or concerned with, the actual *number* of consultants at that time. On the contrary, the Spens Committee was concerned solely with the task of evolving a satisfactory system of remuneration for consultants, of whom it said: " We are satisfied that there is far greater diversity of ability and effort among specialists than admits of remuneration by some simple scale applicable to all. If the recruitment

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and status of specialist practice are to be maintained, specialists must be able to feel that more than ordinary ability and effort receive an adequate reward. Moreover, a reward which would be appropriate when these exist would be extravagant when they do not. In consequence we are clear that any satisfactory system of remuneration must involve differentiation dependent on professional distinction." (Paragraph 13.)

(24) From this and the succeeding paragraphs of its report the Spens Committee made it clear that in its view the remuneration of a consultant should rest *primarily* upon an assessment of individual ability, the main purpose of the basic salary scale being to reward the younger consultant for the progressive increase in professional skill and experience to be expected during the initial years of his appointment.

(25) To ensure a satisfactory spread of incomes in the higher age group, and to reward the younger consultant of outstanding ability, the Spens Committee recommended 3 distinction awards to be granted to fixed percentages of the total number of eligible consultants.

(26) The Committee believes that the considerations which led the Spens Committee to make this recommendation are still valid, and that there would be no justification for departing from it because of changes in the total number of consultants.

G. *Q. 524–529*

Question:

Can the Joint Committee provide evidence as to the effect of the Health Service on private consulting practices ? What is to be inferred from the growth of the Provident schemes ? Can such schemes provide figures which could throw a light on this point ?

Comment:

(27) Although the Joint Committee has no figures showing the effect of the Health Service on private consulting practice earnings, there can be no doubt that the effect has been a disastrous one. This is evidenced by the reduction in the number of hospital private beds since 1948, and by the closure of many private nursing homes. For example, in Newcastle, before the Health Service there were 161 nursing home beds available for the use of the consultants. There are now 61 available to a substantially increased number of consultants. At December, 1955, the number of private beds in N.H.S. hospitals throughout Great Britain was 6,409—i.e., 1·2 per cent. of the total of 548,045 hospital beds.

(28) The amount of private consulting practice still available varies from area to area, from specialty to specialty, and from consultant to consultant. In central London the decline may not be so marked as in most other places, but this is in no small measure due to the numbers of visitors from other countries seeking advice and treatment in the Metropolis.

(29) In paediatrics private practice has severely declined. This is thought to be due to the improved amenities of children's hospital beds and to the heavy expenses incurred by parents in the maintenance and education of their children. In specialties such as pathology and radiology the fall in private practice has been most marked.

(30) One factor influencing the amount of private practice, to which the Committee has already referred, is the high cost (and in some cases the poor quality) of the private accommodation in hospitals.

(31) The cost of providing hospital treatment with all its modern procedures and aids has become so high that were it not for the Hospital Provident Schemes none but the very wealthy could now contemplate private treatment at all.

(32) The popularity of the Provident Schemes since 1948 indicates that there is a substantial section of the community who would wish, in the event of hospital treatment becoming necessary, to arrange for it privately. The benefits provided by the Provident Schemes, however, do not normally cover the total expenses which the patient has to meet in the way of hospital bed charges and professional fees. This is significant because the majority of members of the Provident Schemes are people of modest means. It is understood that the organisers of the Provident Schemes are already concerned at the growing gap between their benefits and the cost of treatment. A substantial increase

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clear: "At present the grants made to Hospital Management Committees"—for the purpose of buying books and so on—"are inadequate and the libraries of few hospitals are satisfactory. The majority of medical periodicals and books essential for the maintenance of professional standards have to be purchased by the individual". Whom have you in mind in particular there?——I think that applies particularly to the whole-time person and the young man working whole-time in the hospital where his income is not sufficiently large to let him subscribe to a number of journals which may be important to him. We feel very strongly that it is there that the hospital should provide at any rate the main structure of literature, because as you are aware, medical literature at present is voluminous in the extreme.

5043. We have appreciated that a little, I think! I am now moving on to the next section. Is there any matter in any of these sections that you would like to add to what you have already submitted here? If so, will you take the opportunity when we are dealing with the section?——Thank you very much.

5044. "Difficulties encountered by Members of the Registrar Grades". I am in some little difficulty here, because you advocate in paragraph 27 an increase in the salaries of these two grades as urgently needed. Then on the very next line, in paragraph 28, you say: "Attention needs to be given also to the career prospects in these grades. Senior registrars are too numerous, in relation to the number of consultants" and so on. Now, if you make the salaries of the senior registrar and the registrar more attractive they would become even more numerous, would they not?——As you know, at the present time the competition for a senior registrar post is extremely severe. The number of applicants for any senior registrar post in general medicine and general surgery may be anything up to 15 or 20, all people who at that time might be considered very suitable for such a post. There is always that barrier at the senior registrar level and we think there will always be considerable competition for those posts. The other factor is those posts are governed by the establishment, an establishment that is agreed between ourselves and the Ministry from time to time. The point, I think, that is rather made out in the slightly contradictory phrase is it does not apply only to senior registrars; it is the registrar below the level of the senior who also is in difficulties as regards his future prospects.

5045. *Chairman*: When you say that the competition for a senior registrar's post is extremely severe, is that because people want to be senior registrars or because they want to pass through that grade to become consultants?——If anyone is applying for a senior registrar post it almost implies that he has decided on taking up that speciality or a branch of that speciality as his permanent career. He may not achieve it but the vast majority of those senior registrars who have served a first or second year successfully will probably become the consultants of the future.

5046. He is applying for that job as a training post for a consultant?——As a training post for a consultant. That is really the main entry point into the consultant field.

5047. *Sir David Hughes Parry*: You would agree, would you not, that it is difficult to get into general practice once you are a registrar?——Yes.

5048. If you attract more to it than you can absorb, then you are creating a problem again. But there is an establishment and therefore you cannot take more but you can attract a better class; is that right?——Yes, that is it.

5049. *Chairman*: There is a very sharp distinction, is there not, between a registrar and a senior registrar?——Yes, very sharp.

5050. *Sir David Hughes Parry*: I have nothing on "Emigration" to raise unless you have anything to add. "The relative advantages and disadvantages of different forms of service" begins at paragraph 35. We want to compare the advantages and disadvantages of part-time and full-time service; we regard that as a very important matter. I have looked through the different documents we have received and I have here listed a number of the advantages and disadvantages of the two, full-time and part-time consultants. I would like you to help us to see whether we have got

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the right answers. The advantages of the part-time service seem to me of two general kinds: there are the advantages by reason of the conditions of service, and there are advantages derived from a better position as regards assessment by the Inland Revenue. You also in several instances have emphasised that the part-time person has an advantage in independence of outlook, and you also emphasise his freedom to practise privately. Those are the four main classes of advantages which the part-timer may have; is that right?——I agree.

5051. I am not going to deal with the matter of independence or his freedom to practise privately, because they are not in the National Health Service, if I may put it that way. They are not strictly relevant on this particular point. I want to compare the part-time and the full-time. We will take the items, I think, mentioned in this document. Would it be right that the part-timer is better off as regards travelling time? ——Yes, that is certainly so.

5052. Then secondly the sessions are calculated by assessing the hours required to perform a given job, and then those hours are divided into sessions? ——I would like to comment on that. When we agreed with the Ministry officials on the estimation of sessions we kept them very rigidly to half days. The question of hours came into it in order to give guidance to the Ministry, but that was never intended to be an exact computation of the number of hours done in any hospital. As you know, we would be extremely resistant to any idea that we should be clocked in or clocked out in any form in the profession. We felt that perhaps the calculation of time and the importance given to it by various Boards has been quite out of the spirit of the original agreement. Every man may work at a different speed, but essentially what a man gives in half a day was to be the unit by which the part-time work would be assessed, without ever having to go down to details of hours and fractions of hours.

5053. In general, the hours are rounded up into sessions; is that right?——They are rounded up. I do not think that that is what we refer to as being exactly the spirit of the thing. The original contract of the part-timer was made with the Board of Governors or with his Regional Board on an assessment of the work he would be doing, roughly split into half days, not into the number of hours he spent at one hospital and then the other. It is impossible to compute the amount of work any one man does in a unit of time. Some may work faster, some may work slower, and we have always held this half-day basis as being the only really fair assessment.

5054. *Chairman*: I suppose it is also true that from one time of the year to another the load on any consultant can vary very considerably?——It may do in some branches of the profession but I do not think it would apply in the general streams of medicine and surgery. I think the load is fairly steady; not even August and September seem to bring much relaxation.—*Dr. Stevenson*: I am not quite sure why Sir David thinks this particular point is one of the advantages of part-time service.

5055. *Sir David Hughes Parry*: One fact is that the hours are always rounded up.——Well, if that is to be the interpretation, there was always a certain amount to be allowed for emergencies and extra visits, visits that anyone pays to a hospital, shall we say, on his own just to see how this and that patient is getting on, which was not part of the original form of contract.

5056. He could choose the time?——In that sense he could choose the time, whereas on the actual sessions he is on a fixed time schedule.

5057. *Chairman*: Is it correct that in the actual Terms and Conditions of Service the number of hours per week for which a part-time specialist should be paid is determined by a prescribed method which does involve a rounding-up?——Yes, it does.

5058. I think that is a fact?——But I think it does say that this is only a general guide.

5059. Yes?——I have not the exact words before me, but I think you will find the timing method was only given as a rough guide to help people assess the original contract session.

5060. Is it not so in most parts of the country, that what you suggest has really happened, that it has been used as a rough guide, and that an assessment has been made as to whether a job is a five or six or eight or nine session job

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It is a matter of great risk at the present time.

5081. That would mean a substantial number of sessions would mean all the greater security from the State?——The man who is approaching the maximum is more secure, in one sense.

5082. You mentioned that the young man at the early stage with only two or three sessions was pretty insecure. I want to put it to you that the man who has seven or eight sessions and a private practice has the security of the State behind him; that is the other side to it.——The young man, of course, is not likely to have any appreciable private practice. That comes more in middle age.

5083. But it is a great security for a man getting on in years that he has the State behind him as well. We are trying to get at their relative position because we think it is very important.——Yes.

Chairman: You were kind enough to give a good deal of evidence on this point in December last, and Dr. Hill gave us his personal position in some detail, so we do not want to go into this in very much more detail.

5084. *Professor Jewkes*: There was what I thought was one new idea that was put to us in your Supplementary Memorandum that bears directly on this subject. It is on page 1134. You are talking about whole-time and part-time consultants there and you mentioned that when a whole-time consultant transfers to maximum part-time, he "almost invariably gives his employing authority an undertaking to continue to fulfil all the duties of his appointment as hitherto". That is a quotation from your document. That would be a case where the part-timer would be under a serious disadvantage because he would be taking a smaller salary for the same work.——*Dr. Rowland Hill*: It really depends upon what you mean by a disadvantage. It is a worth-while disadvantage. It is a slight liberation; it is just that little bit of extra freedom. Although it brings in an element of insecurity, most men hope to make that up, at any rate by a modicum of private practice. For example, in one of my hospitals at the present time a whole-time radiologist and a whole-time pathologist have both applied to do maximum part-time for the very reasons that I have mentioned—they want to get out of the whole-time atmosphere a little bit. That compensates for the loss of two sessions.

5085. *Chairman*: Can I follow Professor Jewkes' point a little further? Do you know of any cases in any hospital where somebody who has been whole-time, which is 11 sessions, has gone on to maximum part-time, which is 9 sessions, and another consultant, a young budding one, for instance, has been appointed for the additional two sessions; or does that never happen?——I think in all my experience of a good many non-teaching hospitals I have never known it happen.—*Mr. Holmes Sellors*: The majority of the advertisements, as they appear, are for whole-time or maximum part-time. But I gather the appointing Committees allow the successful candidate to decide which course of action to take after being appointed.

5086. *Mr. Bonham-Carter*: In fact the same amount of work would be done?——The same amount of work would be done. A number of those on maximum part-time, of course, actually undertake more sessions than the nine. I believe my number, at a rough estimate, is in the neighbourhood of twelve or fourteen.

5087. *Sir David Hughes Parry*: Do you think we have now got the advantages and disadvantages of part-time and full-time, apart from income tax?——I think so, Sir. I would just like to emphasise again, as Dr. Rowland Hill has said, the rather spiritual side of the independence that a great many of us attach so much importance to.

5088. Let me go just one step further on that. In paragraph 38 you make a lot of that: you say that the whole-time consultant lacks the sense of professional independence. I am not concerned with his work with his private patients, but does that affect his work in any way within the National Health Service?——No, it would not affect that at all. The whole-timer and the part-timer are the two people who are giving exactly the same type of service professionally. The difference is in their own mental outlook to it; that is the easiest way one can explain it.

5089. Is that reflected in the National Health Service?——It is not reflected in the National Health Service itself.

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5090. I think we are agreed on the income tax advantages of the part-time person?——Yes.

5091. The question of the car seems to be quite an important item?——Yes.

5092. The question of the telephone? ——Yes.

5093. The question of the instruments? ——Yes.

5094. And books and journals?—— Yes.

5095. And attendance at conferences? ——Yes.

5096. Our difficulty is that we cannot alter the law; we have got to take the law as it stands. You are not claiming better terms for members of the National Health Service than for members of other professions, are you?——If it was included in the terms of a man's engagement that he should have certain things available for the correct performance of his work, that would overcome that.

5097. But that would give him a great advantage over other people earning fees?——Well, I wonder if the medical profession is not in a rather individual position. The telephone may be a universal object but it is an absolute necessity to any medical man.

5098. The advantages of the part-time person are quite substantial, we would agree with you.——*Dr. Rowland Hill*: They are the disadvantages of the whole-time person. They are like galley slaves.

5099. That leads me on to my next question: that probably suggests that there might be a little more weighting for the full-timer as we cannot affect the income tax position in his favour. *Dr. Stevenson*: May I just add this? We never expected anything except to operate within the scope of the existing income tax law. But I might, with respect, draw your attention to paragraph 53 which, of course, is the alternative way of dealing with the problem. We think that the whole-timers have never had the intentions of the Spens Report properly implemented on these particular expense items.

5100. The difficulty would be that it would put your profession in a different position from others.——*Mr. Holmes Sellors*: I do not think so. The Spens Committee did make certain recommendations which we consider have not been fulfilled in connection with these expenses.—*Dr. Stevenson*: I will give a simple example. A whole-timer is required, for obvious reasons, to be in possession of a telephone. The Board will pay him for outgoing calls but unless his income is below a certain level, which is a low one, he is entitled to no reimbursement for telephone-rental. That is only an example, but it shows one way in which his position could be improved.

5101. *Mr. Gunlake*: Could we go back to the tax angle? I thought I understood Mr. Holmes Sellors to say that if a consultant's employing organisation were to make it a condition of his contract that he should have a car and so on, the tax relief would be allowed. Did I understand that correctly?——*Mr. Holmes Sellors*: I am not sufficiently well versed in income tax law. He ought to be able to recover the expenses from his employing authority; that would be a more accurate way of expressing it—just as we mentioned in the case of the telephone.

5102. The expense, not the tax?——I do not know that he could.

5103. *Sir David Hughes Parry*: He would have to pay tax on any relief that he might obtain in that way.——*Dr. Rowland Hill*: I believe this is where Health authorities could operate within the law if they were a little more generous. A phrase in regard to a whole-time officer's salary is that the income tax authority will allow him relief on expenses which are necessarily incurred in the course of his employment. Time and again we have asked the Ministry of Health and that still more static body, the Management Side of the Whitley Council, to instruct the hospital authority to embody that clause in the whole-timer's contract. But they have never consented to do so. The result is that no whole-time consultant, although a car is absolutely necessary to him, has ever had it put into his contract that the possession of a car is necessary to his post.

5104. *Mr. Gunlake*: That is the point I was trying to pursue. Why have they refused?——Perhaps in public I ought not to express my views as to why. It seems to be a lack of wisdom and a lack of a general breadth of mind and a general Northcote Parkinson outlook.

Sir Hugh Watson: It is quite possible, coming back to Mr. Holmes Sellor's

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point, that the Spens Committee should not have said what they did about presuming what the income tax authorities would do. I do not think, with great respect, that Sir Will Spens had any right to say that, because, as you appreciate, this affects many other professions besides yours. I do not think we should blame the Inland Revenue authorities for that.

5105. *Chairman*: You know, Mr. Holmes Sellors, that the figures about consultants' earnings in response to our questionnaire will be coming in quite soon; in fact, some are in already. As I understand it, we shall get a pretty clear idea of the spread between the different numbers of sessions, whether it is one, eight, nine or whole-time. We will find a particular relationship, no doubt, between the part-time and the whole-time. But that will not by itself take any account of the difference in tax treatment on the point of the expenses. That might be something that, since we are not concerned with the income tax law, we might require to take into account. Is that also your point of view?——*Mr. Holmes Sellors*: That would be perfect. We know quite well we cannot touch anything to do with the income tax through this or any other body.

5106. *Professor Jewkes*: Leaving income tax on one side, could you give us some lead on this matter: which of these differences between whole-time and part-time consultants do you think is most important? Am I correct in assuming that it is domiciliary visit payment?——No, I do not think that is the important one; I think that is the least important of what has been mentioned. I think the question of car expenses and travelling time are more important. I think travelling expenses and for a medical man the presumption we must make is that that means a car, which at the moment, as you will appreciate, means expending a very large sum each year.

5107. *Chairman*: We have understood, particularly from Dr. Rowland Hill, that for the man to have his freedom is perhaps the most important of all things?——*Dr. Rowland Hill*: I think there is no question about that.

5108. That is what you said in December.——That is what compensates for all the disadvantages of being a part-timer. That is why, perhaps, I find the word "disadvantage" a little difficult to follow. There are acceptable disadvantages.

5109. You are, I think, saying, Dr. Hill, that it is worth having a little bit less remuneration in order to have your freedom. Your total earnings might be a little less, but in order to justify the freedom you are prepared to accept that?——I emphasise that with great force, yes.

5110. You would not think that the earnings of the part-timers, the people of about comparable ability, ought in fact to be higher than the earnings of the whole-timer?——*Mr. Holmes Sellors*: I think that is entirely dependent on facilities outside, in other words, private practice. That will be their other definite source of income which doubtless will be included in the figures you will receive.

5111. I am just trying to get at what Dr. Hill, I thought, was saying, which was that on the whole the whole-timer should not earn less because he has the additional disadvantage of being a galley slave?——*Dr. Rowland Hill*: Yes. We do not want any section of consultant to be treated inequably. But there is no doubt that if no such thing as private practice existed and if there were no differences in income tax law, it would still be the case that the great majority of consultants would wish to be part-time because the great majority of men—I cannot speak for some future generation, but the great majority of the present generation of consultants—do not wish to be whole-time salaried officers of a public body.

5112. *Sir David Hughes Parry*: I am very interested that the movement is in favour of maximum part-time. That means maximum security as well as independence?——*Mr. Holmes Sellors*: Not maximum security; it is only maximum part-time.

5113. It is maximum under the system as it is now.——*Dr. Stevenson*: Could I come back to something you said; I was not quite sure what the import of your question was. I think you said we would be in favour of there being a possibility of the part-timer getting less than a whole-timer. I think probably we would like to say, if that was the point of the question, the weighting, which no doubt you will be referring to later, was intended to compensate for some of these

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disadvantages inherent in the part-timer's contract.

5114. *Chairman*: Yes, I appreciate that.——I think that is important.

5115. *Mr. Watson*: Dr. Hill did not put it that way. He placed a great deal of stress and weight on what he termed the spiritual release of a consultant. Would Dr. Hill accept it as a general principle, applied to the Health Service as a whole, that the persons employed full-time should have a higher form of remuneration than those who have got a spiritual release and who are part-time with a private practice?——*Dr. Rowland Hill*: I would not have said that, Mr. Chairman. I would accept that the pro rata remuneration for hospital work in the Health Service really ought to be the same.

5116. *Professor Jewkes*: By the same, you mean roughly what it is now?——Yes.

5117. *Mr. Bonham Carter*: May I clear up one point which bothers me about what has been discussed on income tax? It always surprises me that you have got a uniform treatment from Inspectors. One's experience of dealing with people all over the country is that one gets rather different treatment from different Inspectors. Is it your experience that you get exactly the same?——*Mr. Holmes Sellors*: I think what you say is perfectly true. I think the Inspectors interpret quite differently in different parts of the country. That has been one of the difficulties in another discussion we have been having before the Special Commissioners. It is not always the same; but by and large the principles that have been established are the main features and operate fairly generally over the country.

5118. *Sir Hugh Watson*: Could I clear up one point? We know that a maximum part-time consultant is responsible for his patients whole-time, and we know that you yourself have said you do twelve or fourteen sessions. There was a statement in paragraph 60 which puzzles me in that connection: "... few consultants can devote as much time as they would wish to seeing a new patient at hospital. Private practice makes it possible to see patients at greater leisure ...". What does that mean?——If you take a session of out-patients at which there are 15 or 20 new patients to be seen in, say, three hours, it is quite clear that less time will be given to those patients than in seeing a private patient, when often a half hour or an hour is allotted to each patient.

5119. You have got to limit your sessions to three hours?——Not to limit, but there is a session basis and the appointments system gives new patients and old patients to an individual consultant, as many as they think he can deal with in that particular out-patient session.

5120. As many as he can manage?——If he had to deal with all the list that came to him, say, every afternoon he was doing out-patients, he might never finish until midnight or after.

5121. That is where your twelve or fourteen sessions might come in?——Well, there has to be some limitation unfortunately. I think if I may put it rather unofficially, the slight difference in the handling is that, to put it rather crudely, in an out-patients' session the patient listens to the doctor, whereas in a private practice the consultant listens to the patient.

5122. *Chairman*: That again will vary from specialty to specialty?——Yes. A surgical consultation is obviously a much shorter one than a lot of medical examinations.

5123. And it would not apply so much to a radiologist or an anaesthetist?——It would not apply so much.

5124. *Mrs. Baxter*: I am not clear why the category of whole-time consultant has to be continued at all. Is it merely a question that some specialties require full-time hospital appointments? Otherwise why does not the consultant obtain the spiritual release so strongly desired by working 9/11ths, and why cannot the whole category of whole-time consultants be abolished, thereby releasing everybody both from income tax problems and from the galley?——*Mr. Holmes Sellors*: Of course, there are a number of new circumstances in which a whole-time officer is essential. It is implicit in the terms of work, and speaking, many of us, as part-timers, we cannot dictate to the man who wishes to work as a whole-timer. There is a slightly different outlook on the work. Some people have found they do their best work in the whole-time atmopshere; others feel that nothing would induce

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them to work in a whole-time atmosphere.

5125. *Sir Hugh Watson*: There are still some Britons who are prepared to be slaves!——You said that!—*Dr. Rowland Hill*: I would underline what has been said by quoting the agreement with the Ministry of Health. The Ministry agreed to instruct all hospital authorities that offered contracts to consultants, to the effect that if they wanted a consultant for a given post whole-time they were to give him after appointment the option of heing part-time or whole-time, and there is a corollary to that. Any consultant taken over whole-time into the service in 1948, or even whole-time since, has the right to apply to go on part-time. There is one limiting clause to that. If a hospital authority feels that for medical reasons a given post should remain whole-time, they must say so and the onus is on the hospital authority to show that the requirements of the post are such that for medical reasons it must stay whole-time. With that exception, every consultant should be allowed if he wishes, to become maximum part-time. Of course, the service has inherited from before the service days quite a lot of consultants who had become attuned to a whole-time life, and they comprise to-day the great majority of whole-time consultants in the service.

5126. *Chairman*: I think you are referring to the agreed statement set out in full on page 25 of the factual memorandum,* which does contain the phrase "suhject to the over-riding needs of the hospital service." That phrase might apply with special force in mental hospitals.——Possihly yes, and to people working in lahoratories.

Chairman: I do not think there is any dispute ahout that. It is set out as an agreed statement.

5127. *Sir David Hughes Parry*: There is one question of fact on paragraphs 39 to 41 of your main memorandum. You say "This type of consultant is probahly the most numerous within the Service." Then in paragraph 41 you are more specific. You mention this: "The advantages, hoth financial and non-financial, of the maximum part-time consultant are such that the great majority of consultants—over 70 per cent—prefer this status."

5127A. *Chairman*: I think there was a slight mistake, Mr. Holmes Sellors, in your earlier evidence. You referred to 70 per cent of the part-time people and here you refer to 70 per cent of the whole lot.——*Mr. Holmes Sellors*: I am afraid that is a round figure, and our source of information was in the discussion with the Ministry. They gave us the figures.

Chairman: There is a discrepancy hetween what you say on the two occasions.

5128. *Sir Hugh Watson*: On paragraph 34, which is a quite separate point —emigration—you say that many members of the profession are driven to emigrate and that this reflects dissatisfaction with the present conditions of medical practice. Are you referring to financial conditions, or other things? ——I suppose finance is a very large one, but the other is the very fact of working in what people feel is a State monopoly, and that the prospects of promotion for a large number of young men are very small in this country compared with the conditions they can see overseas. The United States of America will take any number of our well trained young men. Whether they keep them is up to the individual.

5129. *Chairman*: In general, the rate of emigration is no higher than in the population generally?——That I am not prepared to say, but we have lost a great many consultants and senior registrars to the North Americas and other countries, and they have not come hack.

5130. *Mr. Watson*: Could anything he done by retiring consultants and doctors earlier? Do you think any useful purpose could he served hy considering an earlier retirement of consultants and doctors so that the line of promotion could be easier for the younger man? ——No, I do not think so. I think there is a fairly marked resentment on the part of people who are approaching the age of 65 that their services should he considered to be no longer useful to the State.

5131. So the question of emigration has nothing to do with the Health

*Royal Commission on Doctors' and Dentists' Remuneration. Written Evidence Vol. I.

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Service? That is, as such?——There are some people who feel most strongly that they would not work under anything which resembles a State service or is being controlled by any bureaucratic organisation.

5132. *Chairman*: I wonder if Mr. Cocker has anything to say on this? ——*Mr. Cocker*: We find we do get some of our young men emigrating and our position is, I think, considerably worse than that of medicine. We have a number of young trained registrars who have not the remotest prospect of getting a consultant's post because there are not the consultant posts for them. In medicine, taking it over a period of time, there is an increase of about 30 per cent in consultant establishment and for dentists it has only been 7 per cent. Taking a limited period, in the year ended June 30th, 1957, there were seven fourth-year senior registrars. The only appointments advertised for them in 1957 were one of two sessions and one of three sessions. Men are not going to give up seven years of training when, after qualifying, they know there is no, or very little, prospect of getting a decent job and when they have the prospect of going into private practice and at any rate making a reasonable living.

5133. *Professor Jewkes*: I wonder if Mr. Holmes Sellors thinks there is any advantage in raising the retiring age. Have there been any discussions on that?——*Mr. Holmes Sellors*: There have been a number of discussions but if you raise that it upsets the prospects of the younger men considerably.

5134. *Chairman*: Do those who are doing a considerable amount of private practice normally stop doing that and retire from it at the same age?——No, they usually continue in private practice, but it is well known from past years that a man who severs his connection from routine hospital work finds that his practice tends to run down, and as a pure guess I should say they have at least three years' private practice before the run down.

5135. Surgery is something in which the powers decline?——It is an individual matter. It is the old battle, that experience only come with time as does the loss or limitation of faculties which affects each doctor.

5136. But I thought, perhaps, that in surgery the decline in faculties became more important than in medicine.—— Yes, but I do not think surgical faculties are dimmed any more than any other part of the profession.

5137. *Mr. Gunlake*: It has been put to me that it is difficult for a man to carry on after retiring from the Health Service. You reassured me on that, but does the same difficulty exist in some degree in some specialties? Are there some specialties where it is impossible for a man to carry on private practice?——There is, theoretically, access to beds in private hospitals.

5138. Which are expensive.——But it does not stop his ordinary practice. It certainly does run down, but I should say three years was the average time for a person doing a considerable proportion of private practice.

5139. I think the retiring age is normally 65 but a man can be kept on up to 70. Have you any information as to the extent to which that has happened? ——I should have thought it is not done extensively.

5140. Most people go at 65?——Yes, because so many doctors are aware of the pressure from below. They feel that in fairness they should not continue with their work. Indeed, according to the regulations, they should not.

5141. *Chairman*: You have not got any statistics on that?——No. I should have thought the Regional Boards would have that. But if a man is employed beyond the normal retiring age it is usually in a different capacity.

5142. *Mr. Gunlake*: What is the position of people who have retired since the Health Service started, or who are going to retire in the near future? I do not mean those who will retire 30 to 40 years hence but the people who are now retiring and getting a very small pension only under the scheme which applies to them. Their goodwill has no saleable value and never had. What will be the effect on those men? Will there be hardship?——I think a number of them will suffer considerable hardship. A number of them who took out endowment policies are better situated, but those policies may not be worth what they are thought to be. The man only just qualifying for a pension certainly has a very poor income to live on after

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his retirement from the service. I think that has been one of the very real hardships we have seen. The war years have, of course, upset the economic prospects.

5143. *Sir David Hughes Parry*: We have taken the point in your memorandum about the consultant's liability for committee work. There is nothing I want to raise on it, and we have dealt with quite a few points on superannuation. There is only one other matter, on paragraphs 93 to 96, dealing with negotiating machinery. We are leaving a good deal of that for private discussion with you later, but there is a very important matter which we think ought to be raised in public. The last sentence of paragraph 93 reads: "There are, however, strong arguments in support of direct negotiation when major matters of finance or other questions of national importance are involved." Before you reply to that may I explain that we have had a number of proposals on negotiating machinery and we are going into each one as deeply as we can to see how they differ. We want them to be as specific as possible. This is rather general. I do not know if you can assist us by saying what is intended by "other questions of national importance."——I think that would imply the major political issues that we deal with to some extent in direct consultation with the Ministry officials but which, because they may imply certain alterations to the conditions of terms of service have to be referred to Whitley. We are using a double method of negotiation. One is Whitley and the other is one in which we discuss directly with the Ministry officials any questions of alterations in the service not connected with the "Terms and Conditions."

5144. Whatever now is a matter of direct negotiation between the profession and the Ministry and not included in the Whitley machinery, you would wish to be henceforth a matter for this body. Is that what you are asking?——No. Possibly we may be getting at cross purposes or perhaps I have not put it clearly. I do not think we have any wish to alter the mechanism by which we have direct consultations with the Ministry and the Ministry officials or even the Minister himself to deal with questions of policy. When, however, any matter that is covered by the Whitley agreement comes in, it cannot be discussed. It has to go into the Whitley machine. You have heard that we are not entirely satisfied with the Whitley machinery as it works at present.

5145. In paragraph 95 you say: "In addition, the Committee recommends that there should be set up a small advisory committee . . .". Advisory to whom?——Advisory to the Government.

5146. The Government as such? It must be to the Treasury, or to the Prime Minister?——To the Prime Minister.

5147. To the Prime Minister?——Yes. If I may come back, as you probably know we are entirely dissatisfied after 10 years' experience, with the Whitley machinery for dealing with any major matters of finance. We agree that it may be made to work in the smaller, day to day, bread and butter matters, but there has been very much a sort of inverted Micawberism of the management side of Whitley. They are always waiting of something to turn down rather than to turn up, so that we are not prepared to consider dealing with any major finance matters in Whitley if we can help it. In fact, any major alterations have not really been through the Whitley machine. Our original claims were rejected by the Whitley machine.

5148. Other questions of national importance have been dealt with by the Minister of Health?——*Dr. Stevenson*: Nearly everything which a consultant does in the National Health Service is covered by a document which is his Terms of Service. Under the present set-up no amendments to those Terms of Service can be made without the ratification of the appropriate Committee of the Whitley Council. As Mr. Holmes Sellors said, many of the items in the Terms of Service may be of supreme financial or national importance. I should like to give you two examples. The present claim is one of supreme financial importance which is unsuitable for Whitley. It may be that we shall object to the cost of private beds. That has nothing to do with the Terms of Service, and is quite unsuitable for discussion with the Whitley Council. In our opinion it is a body which is quite unsuitable to discuss matters of national and financial importance.

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5149. You are proposing that lay persons should be appointed and they will deal with medical remuneration, directly advising the Prime Minister, behind the back of the Minister of Health? ——Possibly we were a little hasty on that. Obviously they would advise the Minister first.

5150. *Mr. S. Watson*: Is this advisory committee purely for the consultants? ——*Mr. Holmes Sellors*: No.

5151. It is for the whole of the medical service?——When we say national importance what we really infer by that is inflation.

5152. *Chairman*: Dr. Stevenson has just mentioned two particular examples. One was the present pay claim and the other was the price of pay beds. Is it your view that this body of eminent laymen should consider the price of pay beds?——*Dr. Stevenson*: No.

5153. Then who would do it? You cannot have two bodies, one Whitley, which you say should not deal with pay beds, and the other a body of eminent laymen. . . .——Direct negotiation.

5154. So you want three—Whitley, direct negotiation and a body of eminent laymen?——We are quite happy to continue with Whitley on the minor things and we want to continue to negotiate direct on other matters, but in order to stop wrangles on matters of national and financial importance we suggest this third solution.—*Mr. Holmes Sellors*: Ending with the Minister as to final appeal.

5155. *Mr. Watson*: Would it mean that this small advisory body, which, apparently according to this memorandum must be set up in consultation with the medical profession—would that mean that your Committee has in mind a small advisory body without any responsibility whatever being empowered to make decisions?——*Dr. Stevenson*: We have based this really on the Coleraine Committee which, I understand, is a body of lay people who advise the Government.

5156. There is a much different employer-employee relationship there. Does this memorandum mean that this advisory committee would be set up, (*a*) only in consultation with the medical profession and (*b*), without any responsibility whatever, will it have the right to bring forward recommendations? Why should they have no financial or other responsibilities inside the Health Service?——*Dr. Rowland Hill*: We felt there were many difficulties about this matter and would like to put them frankly in front of you because we did not feel we could give an answer, but what did attract us was when we saw the Royal Commission on the Civil Service and the setting up of the Coleraine Committee. In their report they referred to the managerial class and above where compulsory arbitration is not suitable and we feel much the same about the consultant. We were attracted by the conception of a high-level body like the Coleraine Committee which would keep the general financial status under continuing review in the same way as is done in the senior grades in the administrative Civil Service, but we were well aware that there were many differences. Naturally we were troubled about it. We thought we should like to put those thoughts to you, some of the thoughts and doubts we had and whether we should be prejudicing our negotiating powers and potentialities if we said we would hand over the whole of our future financial destiny to the advice of this committee, which, in fact, the higher grades in the Civil Service have done. We felt you could think far better on that subject than we could ourselves, but we want to emphasise this idea of some continuing high-level review on doctors', and particularly consultants', remuneration being desirable rather than having these quinquennial wrangles that we have had, like the one in 1954 and the other one which preceded the setting up of yourselves. Obviously the Government felt the same or they would not have given you your third term of reference.

5157. *Chairman*: I should like to get that clear. We are not trying to argue the merits of what you may think here, but we should like it to he quite precise. I think we are clear—that you say this is primarily designed to deal with the higher ranks of the medical profession rather than the whole of the National Health Service.——*Mr. Holmes Sellors*: We would like all medical remuneration to be subject to this review, but we do not feel that such a committee should have a place in determining alterations in our structure. There are obvious difficulties in appointing an eminent body of laymen with rather limited terms of reference. That we appreciate, but

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we are seeking to stop this interminable wrangling and definite ill-feeling that goes on between the profession and its employers.

Sir Hugh Watson: The difficulty is very real. It was put by Sir Thomas Padmore that on all these matters they were going to have the last word. Successive Governments have always taken up that position. We are looking for something to bridge that gap.

5158. *Chairman*: I think you make the point in paragraph 96. You do not, however, Mr. Holmes Sellors, simply say that it is to keep under continuous review the general level of remuneration of doctors eugaged in the National Health Service. You give one particular qualification to it—" in order to maintain their proper economic and social status in the community ".——Since this document was written we have been engaged in a number of discussions, trying to sort out this problem or to make some reasonable, concrete suggestions on it.

5159. *Professor Jewkes*: Might I ask Mr. Holmes Sellors this. This business of trying to draw a line round the reviewing body and deciding that these are the problems which it must deal with and those are the problems which the profession must deal with, is really vital. I can quite see that the kind of pay claim you have already made would come to any proposed reviewing body but you say, " We do not want that body to deal with questions of distribution ". Supposing something had gone wrong with distribution inside the profession and substantial changes were wanted in the relative earnings of the different branches in the profession, would that come to the reviewing body?——I think we should prefer to work out any question of distribution more locally. I think we feel there would be too much danger of an eminent body deciding to change the structure by altering the salary scales, by altering them substantially. We feel that if we did not have some say in that we should be very unhappy.—*Dr. Stevenson*: I think we have said on another occasion that apart from the disputes to which Mr. Holmes Sellors has referred there have been few occasions on which we have not been able to reach agreement with the Ministry on these matters.

5160. *Chairman*: Can I go a bit further as between the first two of your methods? Have you got a fairly clear dividing line as to the difference between those things which should be dealt with by Whitley and those dealt with by direct negotiation with the Ministry?——*Mr. Holmes Sellors*: I would say I have a fair idea in my own mind, but whether I can make it clear to you is another point. In Whitley there are the bread and butter matters which affect the terms and conditions of service. On that we are satisfied. In the other field of direct negotiations with the Ministry officials again we are satisfied on matters of policy. Matters such as are likely to be pressing with us, the cost of pay beds and the like, we feel should be discussed directly with the Ministry officials. In Whitley we are discussing with an amorphous body. It is always the Paymaster element which comes into Whitley, and you feel that very strongly. Whereas in negotiation, where we are both trying to find a satisfactory solution we come very much to a reasoned agreement in our discussions across the table with Ministry officials or with the Minister himself. The agenda of our meetings are usually full of residual points which are important locally within the profession but are not concernecd with any great alterations in remuneration.

5161. You add in your memorandum that the Whitley machinery requires to be drastically overhauled. Again I am not quite sure what kind of drastic overhauling you mean.——I think I have expressed the essential point. The whole point is that the staff side feel that there is Treasury control, that on any suggestion for any alteration of money the instruction is coming to the management side from the Paymaster.

5162. *Mr. Watson*: That is really inevitable.——We agree, but it does not make for easy discussion.

5163. Can you take it to the next stage? You suggest that the management side should be composed of Government officers with real authority to negotiate with the staff side. Those are the words you use. I take it you mean the Treasury should second responsibility to its officers to reach wage settlements with you?——*Dr. Stevenson*: That is what happens in other fields, the general practitioners' field.

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5164. I am not saying it is not. But if that is so, what is the need for the advisory body? If you wish to have a Whitley Council on which the representatives of the Government, and the Treasury, go, with real authority to settle, why do you want any other authority? ——*Mr. Holmes Sellors*: Because ten years experience of bringing forward any major issue does not encourage us.

5165. It is your recommendation, not mine.——*Dr. Rowland Hill*: What we really felt was that when on any big major issues which we are responsible for, the Minister says "This is going to have some impact on national financial policy and will have to be considered at that level," that is where a high level committee might, we feel, be the best body to discuss it with. In 1954 when we made a claim on the fallen value of money, the Minister at that date interviewed us and explained the extreme difficulty of meeting the claim in the light of the national situation. It is a good many years ago now but I think he told us he was inclined not to permit any arbitration on that claim. It was only after prolonged negotiations that the 1954 agreement was reached. What we feel about Whitley is this. We feel that in smaller matters we never get to grips with the people who can say Yes or No. I believe that the Civil Service Whitley Council works rather well ; I understand that the employing side is known as the official side, and the official side in that Whitley Council appear to have much more power of decision than has what we call the management side in our National Health Service Whitley Council. A large percentage of our management side is composed of members of Management Committees and Regional Hospital Boards who really have no power of decision, and that undoubtedly produces protracted misunderstandings and lengthy discussions. The misunderstandings spread and no decision is reached month after month.

5166. I wonder, Mr. Holmes Sellors, if we can continue on this. Quite frankly, some of us are very anxious to find a medium of negotiation. You say in this document that this body, the advisory committee, should be charged with the continuing duty of tendering advice to the Government on its own initiative. Has the Council really thought out the responsibilities of such a committee and if it is going right down through the Health Service from A to Z, making all kinds of recommendations, such as, for instance, on the retiring age or a change in the per capita basis?—— *Dr. Stevenson*: No.

5167. I am just asking if you have thought of all these possibilities. Is your purpose to limit this body only to one thing, the question of wages?—— *Mr. Holmes Sellors*: That was our idea. The issues at the back of other people's minds as to whether the body should be a different one from what it is now, are not relevant.

5168. But you say "questions of national importance."——On that, which I think we have drafted badly, we did mean inflation or wars which are outside the course of economic and financial progress.

5169. *Professor Jewkes*: So you are suggesting for the reviewing body one task only, to give advice on the total sums which would be made available for payment of consultants and general practitioners in the National Health Service? There would be one figure?—— Yes.

5170. *Chairman*: I think I am right in saying that the only drastic overhaul of the Whitley machinery which you are asking for is for Whitley to be composed of people who can give an answer then and there?——That is it.

5171. That is what you are asking for, or have I simplified it too much?—— No, we have had ten years' experience of it.

5172. *Mr. Gunlake*: You would like to have people to come to the conference with open minds and not closed minds?——Exactly.

5173. You have the impression that at the moment they come with their line prepared?——*Dr. Stevenson*: They have met in the morning.

5174. *Chairman*: Is it also possible that you have made up your minds? ——We try to anticipate what the other people will say.

5175. *Sir Hugh Watson*: But the occasions when that sort of thing happens, arise when there is a really major question of an increase of remuneration or something of that sort. ——*Mr. Holmes Sellors*: They will do

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it on almost any issue. Supposing we suggest a slight increase in the remuneration for giving lectures. That is the sort of negotiation that may take nine months, going backwards and forwards.

5176. You are in a different position from the general practitioners. Many of their discussions are concerned with re-distribution of the pool?——We chose to go to the Whitley Council and we have Committee B. Whether there might have been some other alternative I do not know.

5177. *Chairman*: I take it that when you go to Committee B you have done a certain amount of preparing with the other side. You are not putting quite suddenly, out of the blue, that you would like a change in the system?——There is a long exchange of documents.—*Dr. Stevenson*: We must be honest on this. I think you have put your finger on a real difficulty of Whitley, that the two sides do meet independently in the morning and consult in the afternoon, so that on many occasions it is not possible to get a decision immediately but in three months' time.

Sir Hugh Watson: You could not consult in the morning and meet in the afternoon, could you?

Chairman: I do not think there is much we wish to ask on your Supplementary Memorandum. It has a lot of very detailed information in it, in reply to questions which have been put, for which we are very grateful, and in fact some of this has been touched on in the earlier evidence this morning.

5178. *Professor Jewkes*: I have one point. In this memorandum you give evidence about the difficulty of getting registrars and senior registrars in a considerable number of hospitals in this country. The interesting statistics you give show the extraordinary dependence of a number of hospitals on foreigners. Does this mean that really the system is precarious in the sense that if these foreigners were withdrawn the hospital system would break down?——*Mr. Holmes Sellors*: In certain circumstances I think that is true. In one of my hospitals I am served by three people from India, there being no applicants from this country. In fact, we have not got a British born person on the hospital staff.

5179. *Chairman*: And this is more evident in the non-teaching hospitals?——Yes, the non-teaching and peripheral hospitals. The young man tends to like to be central.

5180. May I come back to the point we have left? If something prevented Pakistan, which happens to be a big contributor, from sending a lot of people over here and there was a considerable difficulty in filling some of these posts, which of the bodies you have mentioned do you think should take the necessary steps to ensure that there was a proper filling of the posts on the perimeter as well as in the centre?——That would come under direct negotiations with the Ministry, and in anticipation of a number of these problems the Minister has formed a Working Party of which there are several members before you now.

5181. If there is a shortage which suggested that steps should be taken to make certain types of post more attractive would you think that would go to Whitley?——I think that would be more a question of approach to the senior officials of the Ministry or to the Minister himself.

5182. So you put it in category two —direct negotiations?——The direct negotiation system works well and works relatively easily, because it is simply a question of finding suitable dates. That is very easy in present negotiations, I trust on their side as well as ours.

5183. *Sir David Hughes Parry*: How are those persons trained? Are the Indians and the Pakistanis trained in this country?——There is a mixture of both. Some have been through medical schools in this country; others have come over as post-graduates.

5184. That is an important part of their training?——Yes.

5185. But we should not be entirely dependent on them?——I think that is so, but I think we should fulfil our obligations of training post-graduates if they come to this country.

Chairman: What would seem to be desirable is that there should be a spreading of these people throughout the hospitals and not a concentration.

5186. *Sir David Hughes Parry*: And our own registrars want to be under the eye of the professor and those in the teaching hospitals and those associated

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with them?——On the whole, yes. They do, of course, get the opportunity of greater freedom of action in the peripheral hospitals.

5187. They have one eye all the time on their own future?——Yes.

5188. *Professor Jewkes*: May I then draw the deduction that there is a shortage of British registrars?——In certain areas there is most undoubtedly in the number of applicants. I am not prepared to say whether it is due to any sense of insecurity that they are not continuing in the hospital service. We know the difficulty of getting the senior registrar posts filled.

5189. *Sir David Hughes Parry*: Might it not be that many of them go into the Forces at this time and do their National Service? When that ceases there may be better opportunities?—— I should think that might be true. But National Service has worked in another way. The man who comes back from the Forces very likely feels he would like further hospital experience before he decides that he can go into private practice.

5190. *Chairman*: Is the registrar grade partly a training grade and partly a staffing grade?——It is the obvious course through which a man, in deciding on his future, will pass. It is a training grade.

5191. *Sir David Hughes Parry*: The extension and the increase in the number of registrars was a staffing problem? ——Yes, and with the complexity and development of modern medicine a lot of people are needed in this way.

5192. *Sir Hugh Watson*: What happened before?——The team was a very different one. The team at a teaching hospital was a full surgeon and a junior surgeon, both having consultant rank, with one registrar who was the equivalent of the senior registrar at present and one or two house surgeons. At the time when the Health Service started and the post-war people were coming back, there might be two consultants, from one to three senior registrars and two house officers. With some of the specialist teams we carried even as many as four or five.

5193. What happened in the non-teaching hospital?——In the non-teaching hospitals there were a number of medical officers under the administrative control of a superintendent or the senior man and then there were a number of house officers scattered about in accordance with the needs. There was no attempt to have a team.

5194. *Sir Hugh Watson*: But what I mean is this. The people from Sheffield paint a picture—and I know it is not confined to Sheffield—that the service would break down if we did not have these people from abroad. What happened before?——*Dr. Rowland Hill*: The effect of the Health Service in the teaching hospitals has been twofold. First, there was a great increase in the amount of work. For example, the effect of it on my own work was to double or treble the amount which came my way. Secondly, the immediate effect of the introduction of the National Health Service in 1948 was to upgrade the work of a lot of the hospitals which were, frankly, working before the war at quite a primitive level of medical work. As you know, the first attempt of the National Health Service was to spread the consultant standard of work evenly throughout the country and that at once meant an increased need for staff in all these hospitals.

Chairman: I think we will break off our public discussion at this point.

(*The proceedings were continued in camera.*)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

22

Twenty-Second Day, Friday, 12th December, 1958

WITNESSES

Scottish Medical Practices Committee

Scottish Association of Executive Councils

LONDON
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A. I. MILLAR, O.B.E.
J. MCCALLUM
A. B. FAIRWEATHER

Pages 1156–1180
Questions 5195–5298

SCOTTISH ASSOCIATION OF EXECUTIVE COUNCILS

J. M. GILL, M.B., Ch.B.
COLONEL R. S. WEIR, C.I.E.
T. HUNTER, O.B.E.
A. R. HOWIE

Pages 1181–1215
Questions 5299–5437

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TWENTY-SECOND DAY

Friday, 12th December, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER
MR. J. H. GUNLAKE, C.B.E., F.I.A., F.S.S.
MR. I. D. MCINTOSH, M.A.
SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C.
MR. J. B. HUME
Joint Secretaries

Observations by

SCOTTISH MEDICAL PRACTICES COMMITTEE

on

" Questions and Topics on which the Royal Commission would like to have the views of the Medical Practices Committees "

1. *A brief description of the Committee's own activities*

(Unless otherwise stated, the functions listed below are, so far as the Committee are aware, also discharged by the Englisb Medical Practices Committee.)

The Scottish Medical Practices Committee was constituted in 1948 by the Secretary of State for Scotland under the National Health Service (Scotland) Act, 1947. Under that Act, the Amendment Act of 1949, and regulations made thereunder, the Committee are now empowered to discharge the following duties:—

S. 35 of the N.H.S. (Scot.) Act, 1947.

(*a*) To consider and determine applications from doctors wishing their names to be included in Executive Council medical lists for tbe purpose of providing general medical services. The Committee may refuse an application, or may grant it subject to a limitation of practice area, only on tbe ground that the area or part of the area concerned is already adequately served by doctors. An applicant dissatisfied witb the Committee's decision may appeal to the Secretary of State. The number of applications granted and refused by the Committee during the five years to 30th June, 1958 is given in Appendix I.

S. 36 (9) of the N.H.S. (Scot.) Act, 1947.

(*b*) To consider applications from doctors for a certificate that a proposed transaction does not involve the sale of the goodwill of a medical practice which the Act made it unlawful to sell. The possession of the Committee's certificate is a defence in Court to any charge that an offence under the Act bad been committed in respect of which certificates are sought take the form of partnership agreements. The Committee have prepared a memorandum on the subject for the guidance of doctors or their agents; a copy of this is reproduced at Appendix II. (See also 7.)

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Reg. 7*.

(*c*) To consider reports made by Executive Councils at least once every year, for the purpose of enabling the Committee to judge the needs of the different parts of the country for doctors. The reports are now normally called for at 1st April of each year.

Para. 2 (*c*) of Part II of First Schedule to Regs.

(*d*) To consider applications, referred to them by the Secretary of State, from doctors for inducement payments and to make recommendations. These payments are intended to assist doctors practising in sparsely populated districts, or in districts which for any other reasons are unattractive to medical practitioners. There are at present in Scotland 47 practices which carry an inducement payment.

Para. 2 (*a*) of Part II of First Schedule to Regs.

(*e*) To determine whether an initial practice allowance should be made available in a particular area on the ground that a practice is necessary therein for an efficient service. The allowance may be paid (i) to a doctor setting up a new and independent practice, or (ii) to a doctor succeeding to a small vacant practice. The considerations taken into account by the Committee in determining whether or not a particular district should attract an allowance are set out in Appendix III. (The Committee understand that the position in England is somewhat different.)

Reg. 8 (1).

(*f*) To consider the arrangements proposed by an Executive Council for dealing with a vacancy created by the death or resignation of a doctor, and, if they think it desirable, to require the vacancy to be advertised. The manner in which the vacancies arising in the five years to June, 1958, were dealt with are shown in Appendix IV.

Reg. 8 (3).

(*g*) To consider and determine appeals from doctors whose applications to Executive Councils for succession to vacant practices have been unsuccessful. Appendix V shows how appeals made in the five years to June, 1958, have been dealt with.

(NOTE—(*f*) and (*g*) represent the most important difference between the arrangements in operation in England and Scotland respectively. Whereas in England the filling of vacancies occurring in medical practices is entrusted to the Medical Practices Committee, appeals being to the Minister of Health, in Scotland the selection of doctors to fill such vacancies is a function of the local Executive Councils. The Scottish Medical Practices Committee are only the appellate body, and they have thus no say in the filling of vacancies save in the comparatively few cases where an unsuccessful applicant appeals against the choice made by the Executive Council.)

Para. 8 (3) (*a*) of Part I of First Schedule to Regs.

(*h*) To consider and determine appeals from doctors against decisions of Executive Councils not to grant permission to employ an assistant. In terms of the regulations a doctor is not allowed to employ an assistant for longer than three months, except with the permission of the Executive Council or, on appeal, of the Committee. (See also 3.)

Proviso (iii) to Reg. 16 (2).

(*i*) To consider and determine appeals from doctors against decisions of Executive Councils respecting the extent to which their lists of patients may be increased by reason of the employment of assistants (see also 5). (There is no provision in the English regulations for appeals of this nature. The Minister may, however, direct that the normal maximum number of patients allowed to a doctor shall be increased in respect of the employment of an assistant.)

* Regulation references throughout this document are to the N.H.S. (General Medical and Pharmaceutical Services) (Scotland) Regulations, 1955—S.I. 1955 No. 1942 (S. 148).

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Reg. 2 (2) (*a*).

(*j*) To consider and determine appeals against refusals of Executive Councils to recognise ostensible partners as partners for National Health Service purposes. A practitioner is not, under the regulation, recognised as a partner unless he is in the position of a principal in connection with the practice, and is entitled to a share in the profits of the partnership which is not less than one-third of the share of the profits of the partner with the largest share. No appeals of this nature have been received. (In England appeals against decisions of Executive Councils in this connection lie to the Minister.)

Para. 1 (*h*) of Part II of First Schedule to Regs.

(*k*) To consider and determine appeals against refusals of Executive Councils to pay partnerships on a "notional list" basis. Doctors practising in partnership may have their individual lists of patients calculated notionally, so as to derive the maximum benefit financially from the "loadings" addition to capitation fees in respect of patients between 501 and 1500. Only one appeal of this nature has been received; after a hearing the Committee allowed the appeal. (Appeals of this nature in England lie to the Minister.)

Proviso to Para. 2 (*a*) of Part II of First Schedule to Regs.

(*l*) To consider and determine appeals against decisions of Executive Councils (i) not to make an initial practice allowance available to a particular doctor; or (ii) to discontinue the allowance in the second or third year; or (iii) where the amount payable is in dispute. Appeals of these types can arise only where the Committee have made an allowance available in the district concerned (see (*e*) above). Three appeals have been made and all were allowed. (The Committee understand that the position in England is somewhat different.)

Reg. 9.

(*m*) To consider and determine appeals from doctors against refusals of Executive Councils to agree to a proposed exchange of practices between two doctors. No appeals of this kind have been made. (There is no comparable regulation in England.)

2. *Have the Committee formed any impression as to the quality of applicants, particularly as to any changes ?*

The Committee do not feel competent to make any comments as to the quality of applicants for vacancies since, as indicated above, the selection of doctors to succeed to vacant practices in Scotland is a matter for Executive Councils. It is only when an appeal is made that the Committee are required to consider the merits of any applicants, and then only those of the doctor selected by the Executive Council and of the appellant(s). It can be stated, however, that generally the doctor selected by the Executive Council is well qualified and has had good experience both in Hospital and in General Practice.

3. *Have the Committee any comments on their experience in dealing with appeals against Executive Councils where the Council has refused permission to a principal to employ a permanent assistant (over three months) ?*

The Committee have received only three appeals by doctors against refusals by Executive Councils to allow them to employ an assistant. In one case the doctor decided not to proceed with the appeal; in the second a compromise was reached at the hearing, the Executive Council agreeing to the employment of the assistant for one year provided the assistant was made a partner at the end of the year; and in the third the Committee allowed the appeal. While the Committee have no evidence, they feel that very few principals desirous of employing assistants are refused the necessary permission, Executive Councils usually taking the view that the doctor himself is in the best position to judge whether he requires an assistant.

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4. *Do the Committee think there are within the Health Service adequate safeguards against the exploitation of assistants ?*

The National Health Service Acts and Regulations do not purport to provide safeguards against the exploitation of assistants, and they do not in fact provide any effective safeguards. Consent is, of course, required before an assistant is employed but the Committee have no knowledge of what criteria are adopted by Executive Councils in granting or refusing consent. A regulation recently made requires Executive Councils to review from time to time all consents given to principals in their area to employ assistants.

5. *Do the Committee think it reasonable that a principal should be able to accept an additional* 2,000 *patients if he employs an assistant ?*

The Committee consider that tbe 2,000 additional patients allowed where an assistant is employed is higb. Even in the most favourable circumstances, e.g., an experienced but active principal, a concentrated practice, and an efficient assistant, a total figure of 5,500 patients for a practitioner and assistant seems too much. One appeal has been received from a doctor to whom the Executive Council refused to allow the extra 2,000 patients in respect of an assistant; in view of the special circumstances of the case tbe Committee allowed tbe appeal.

6. *Do the Committee believe any doctors prefer to be permanent assistants ?*

The Committee believe that there may be a very few doctors who prefer to remain assistants, rather than accept the responsibility of conducting a practice on their own. But they bave no evidence on the subject.

7. *Do the Committee think there would be advantage in their having additional powers to see all partnership deeds and agreements for the employment of assistants ?*

The Committee believe that advantage would follow if they had power to see all proposed partnership deeds, and grant or refuse certificates in respect thereof. The probable result would be that in more partnerships than at present the interests of the junior partner would be adequately safeguarded. During the five years to 30th June, 1958, 85 proposed agreements were submitted to the Committee for a certificate under section 36 (9) of the Act. Many of these received a certificate without question: otbers received a certificate after certain matters prejudicial to the junior partner had been brougbt to the attention of the applicants or their solicitors, and appropriate alterations made: in tbe remainder certificates were refused. Appendix VI shows the numbers involved in each category over a period of five years, and also the total number of partnerships that were formed in Scotland in these years.

It will be seen that in 28 of the 85 proposed agreements submitted to the Committee in the last five years (i.e., 33 per cent) the initial refusal of a certificate resulted in the partnership agreement being amended in such a way as to enable tbe Committee eventually to grant a certificate; and in general the effect of the amendments was to safeguard the interests of junior partners. It is, tberefore, not unreasonable to assume that if all proposed partnership deeds had to be submitted to the Committee for scrutiny, a significant proportion of the total number would be adjusted in favour of the junior partner.

As regards agreements for the employment of assistants the Committee believe that assistants are often employed without any written agreement being entered into. Executive Councils are not entitled to require any such agreements to be submitted to them for examination and the Committee do not consider that it sbould be any part of their (the Committee's) duty to scrutinise agreements of this kind.

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8. *To what extent do the Committee effectively refuse entry into closed areas ? Do they for instance refuse entry to practitioners who wish to become additional partners ? Do they permit the advertisement of vacancies or call for the dispersal of a practice ?*

The Committee have never deemed it necessary or expedient to " close " particular areas as the English Medical Practices Committee has done. They have taken the view that every application to enter an area should be individually considered by them, in the light of its own circumstances, and of the conditions prevailing in the area at the time the application is made. Local conditions are, of course, liable to change from time to time, e.g., as regards medical personnel and size of population (which may be affected by industrial or housing developments).

There are, however, one or two parts of Executive Council areas in Scotland from which, in practice, the Committee normally exclude new practitioners—while perhaps granting admission to the medical list for practice in adjacent localities. Whether such exclusion would be imposed in the case of a proposal to practise in partnership would depend on the circumstances of the particular case. (It should be mentioned that a considerable proportion of the applications to join medical lists (and of the refusals of such applications) are in respect of doctors who are on the list of an adjacent Executive Council area, and are desirous merely of extending their practices across the boundary.)

The Committee have no power to stop an Executive Council advertising a practice vacancy, though, in theory, they could prevent a Council filling a vacancy by the appointment of a doctor not already on their medical list, by refusing to admit him thereto. In practice it is unlikely that the Committee would ever wish to object to an Executive Council filling a vacancy in this way. (On the other hand, the Committee have power to require an Executive Council to advertise a vacancy.)

9. *Do the Committee think it reasonable that vacancies in partnerships should, as at present, not be advertised ?*

The Committee regard the non-advertisement of partnership vacancies as reasonable, and would not seek to alter the position where a partner is allowed to choose himself the person with whom he wishes to practise. At the same time they recognise that this state of affairs tends to limit severely the number of vacancies—mainly in partnership practices proper, but also, in some measure, in what are truly single-handed practices—which would otherwise be available for open competition. The explanation of the somewhat paradoxical situation whereby a vacancy in a single-handed practice may be, and often is, dealt with under a dispensation designed primarily for partnership practices (in the true sense of the term) is as follows. A single-handed practitioner who is contemplating early retirement on grounds of age or health may assume a partner on the definite understanding that the latter (1) will provide a measure of relief during the period preceding the practitioner's retiral, sharing the profits of the practice on agreed terms, and (2) will, at such retiral, succeed to the entire practice—subject, of course, to the agreement of the Executive Council (which is normally forthcoming). In such a case the practice is a partnership one only temporarily, and during a strictly limited period (which may be quite short and is sometimes curtailed by death); at the expiry thereof it reverts to its normal and recognised state of being a single-handed practice.

10. *Do the Committee think there are sufficient safeguards against the exploitation of junior partners ? What proportion of partnership agreements submitted to them are unsatisfactory—and for what reasons ?*

See 7 above.

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Since there is no obligation on practitioners to submit proposed partnership agreements to the Committee, the existing safeguards under section 36 are not sufficient to prevent or discourage exploitation of junior partners in all cases. As already stated, during the five years to 30th June, 1958, the total number of applications for certificates made to the Committee was 85, i.e., only about 22 per cent of the partnerships formed in the course of these years. (See Appendix VI.) Accordingly, in cases comprising the majority of the total number the Committee were not informed of the terms of partnership, and there was no safeguard against any exploitation of junior partners. The Committee feel that the fact that the demand for partnerships exceeds the supply will tend to increase the risk of such exploitation.)

The chief reasons for agreements being regarded as unsatisfactory were as follows:—

(*a*) In the circumstances of the particular case the progression to parity of shares was extended over too long a period.

(*b*) Parity was never reached, and the final disparity was either significant in amount or without justification in the circumstances.

(*c*) There was a restrictive covenant which would have been a substantial hardship and which was operable against one partner only.

(*d*) The junior partner was having to bear an excessive share in the expenses of running the partnership.

It will, of course, be appreciated that, as Appendix VI shows, the initial refusal of a certificate owing to the agreement being considered unsatisfactory does not *necessarily* result in its being amended and resubmitted to the Committee—although this happens in most cases.

11. *To what extent do the Committee obtain information about a doctor's outside commitments ?*

12. *What action is taken where such commitments are large ?*

A column designed to show other commitments is provided in the form of annual report submitted by Executive Councils, but in practice the information supplied therein has proved to be of little value. There is, for instance, no indication of how much private practice is undertaken.

Where other commitments were known to exist to a considerable extent, and the numbers on the lists of the doctors concerned were high, a need for additional doctors would be indicated, and the area would be listed by the Committee accordingly.

13. *Would the Committee favour any alteration in the maximum permitted list, either general or in selected areas ?*

The Committee do not regard the present permitted maximum of 3,500 patients as any proper indication of the number who can be adequately served—with justice to both patient and doctor. Even in compact industrial areas such a large commitment represents too heavy a burden. The Committee would stress that a reduction to a lower figure should be regarded as a step which must be taken (*a*) if a satisfactory standard of service is to be provided by practitioners and (*b*) if the medical profession is to be allowed a reasonable amount of leisure. In expressing this view the Committee are not unaware that financial considerations have a bearing on this question; but they would not seek to intervene in a matter wholly outwith their purview. They therefore confine themselves to putting forward the case for a reduced list, and refrain from expressing any view as to its immediate practicability.

The Committee consider that in determining the optimum list a more than purely statistical criterion requires to be adopted. Substantial differences must be expected to exist between figures appropriate to

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sparsely populated rural areas and the larger towns respectively, since in the former case allowance must be made for the greater amount of time expended in travelling. At present, the Committee consider as under-doctored any area where the average number of patients is over 2,500, or 2,000 in areas where other commitments are large, or where a large amount of travelling is undertaken. This leads to the conclusion that the present maximum of 3,500 patients for an individual practice is too high—in any type of area whatsoever.

14. *In considering applications for practice vacancies, what weight do the Committee give to* (a) *previous experience in general practice and* (b) *experience of different kinds in the hospital service ?*

The Committee have very little experience of considering applications for practice vacancies, since, as indicated above, in Scotland vacancies are filled, not by them, but by Executive Councils. Only when an appeal is made by an unsuccessful applicant for a vacancy are the Committee required to consider the merits of individual applicants; and the number of appeals is few. (See Appendix V.)

15. *Could they give information about the ages at which doctors have in the last few years been appointed to these vacancies ?*

The average ages of doctors selected to succeed to advertised vacancies in the five years ended 30th June, 1958 were 36, 39, 34, 37 and 35 respectively, the actual ages ranging from 27 to 57.

16. *Can they indicate over some convenient period what percentage of doctors commencing practice as principals have been registrars ?*

The Committee have no information on this subject. As has been explained, they are not called upon to scrutinise applications for vacancies, save to a very limited extent (in connection with appeals).

17. *Could the Committee explain the principles on which they classify the areas of Executive Councils ? What figure of patients per doctor results in " closing " an area ? What considerations led the Committee to fix the particular figure ?*

The Committee do not adopt any rigid classification of areas.

All areas in Scotland are, in theory, open and a doctor may therefore apply to have his name included in the medical list of any Executive Council, every application being considered on its merits. For the convenience of doctors wishing to set up practice the Committee publish a list of areas where they feel that additional principals appear to be desirable. In these areas the average number of patients per principal is in the region of 2,500 or more.

While, as indicated in answer 8 above, no areas in Scotland have been publicly declared " closed," there are two parts of Executive Council areas (residential districts in counties adjoining the City of Glasgow) where the Committee normally restrict the entry of doctors. In one of these districts there are 13 principals with an average list of 1,344, while 45 other principals enter the district, although their main practice lies in an adjoining Executive Council area. In the other district there are 6 principals, with an average list of 1,369, and 134 principals enter from an adjoining area.

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APPENDIX I

APPLICATIONS FOR INCLUSION IN MEDICAL LISTS DETERMINED BY SCOTTISH MEDICAL PRACTICES COMMITTEE IN EACH OF THE FIVE YEARS ENDED 30TH JUNE 1958

Type of Case		Year ended 30th June, 1954	30th June, 1955	30th June, 1956	30th June, 1957	30th June, 1958	Total
To succeed to a vacancy for which the applicant has already been selected by the Executive Council.	G	43	26	34	19	42	164
	R	—	—	—	—	—	—
To set up new single handed practice.	G	18	9	6	7	11	51
	R	10†	1	3	1	20*	35
To practise in partnership with doctor(s) already on list.	G	82	64	77	59	59	341
	R	1	—	—	—	—	1
To extend existing practice into adjoining area.	G	64	33	61	43	56	257
	R	15	6	1	7	1	30
Total ...	G	207	132	178	128	168	813
	R	26	7	4	8	21	66

G = Granted. R = Refused.

* 21 Applications were made in response to an advertisement for a doctor to set up a single handed practice in a new town; the Committee granted one of the applications and refused the remaining 20.

† 6 Applications were made in response to an advertisement for a doctor to set up practice; the Committee granted one of the applications and refused the remaining 5.

APPENDIX II

MEMORANDUM REGARDING APPLICATIONS FOR CERTIFICATES UNDER SECTION 36 (9) OF THE NATIONAL HEALTH SERVICE (SCOTLAND) ACT, 1947, IN RESPECT OF MEDICAL PARTNERSHIP AGREEMENTS

1. From time to time applications are received by the Scottish Medical Practices Committee for certificates under section 36 (9) of the Act. Most of these applications relate to Partnership Agreements. Experience in dealing with these applications suggests that uncertainty exists as to the implications of the statutory prohibition of the sale of goodwill; as to the purpose and effect of such certificates; and as to the functions of the Committee in relation thereto.

2. This Memorandum is intended to clarify the position, and to indicate the principles on which, as at present advised, the Committee proceed. In the absence of authoritative pronouncements by the Courts, certain questions must remain matters of opinion. In these circumstances the Committee are guided by such experience as they may possess and by such legal advice as may from time to time be available to them. The views expressed herein are always subject to modification in the light of further experience, consultation and advice, and of the special circumstances of each case.

3. A certificate under section 36 (9) represents the opinion on the Committee. There is no obligation on medical practitioners to possess such a certificate. The

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absence of a certificate does not preclude practice, or render a transaction invalid. The sole statutory purpose of a certificate under section 36 (9) is that it may constitute a defence in the event of a practitioner being charged with an offence in respect of the unlawful sale of goodwill. There is no reason to suppose that a practitioner so charged may not justify his action hy other means. Moreover, even when a certificate is granted, its value as a defence is entirely dependent upon full disclosure of all relevant circumstances having been made.

4. The Statute provides that any certificate granted shall set out all material circumstances disclosed to the Committee. If all material circumstances have not been disclosed, or if there has been any misrepresentation, the certificate may be disregarded. It is thus in the interests of applicants to make sure that all material circumstances are put before the Committee. The Committee have no duty to discover these matters from their own sources of information. Applications should therefore emhody not only the proposed terms of agreement, hut an accompanying statement of the circumstances relied upon as showing the absence of any element of unlawful sale of goodwill. Relevant circumstances include all facts tending to show whether there is in fact an existing goodwill which it is unlawful to sell; whether it is intended that such goodwill or any part of it should pass from one person to another; and what are the whole benefits and consideration to be given and received in respect of the transaction. As is hereinafter explained, the age and experience of the parties concerned, and the size and nature and length of establishment of the practice may be of material importance. Merely to submit the bare terms of the proposed agreement can seldom if ever amount to a full disclosure of all material circumstances. If, on the other hand, a full statement of the facts accompanies the application, any certificate granted will be docquetted with reference to that statement of facts. It will then be a simple matter for the Court to ascertain whether the certificate was granted after full disclosure and thus constitutes a valid defence, or whether it falls to be disregarded as having heen ohtained without full disclosure or hy misrepresentation.

5. The ohligation on the Committee is to grant a certificate only if they are satisfied, on full disclosure, that the transaction in question does not involve the unlawful sale of goodwill. If the Committee are not so satisfied on the information furnished to them, there is no obligation to grant a certificate. Nor is there any obligation on the Committee to specify their reasons for refusing a certificate. Moreover, the Committee cannot undertake in individual cases to offer advice as to what ought or ought not to go into an agreement, or to enter into correspondence on points on which an application is considered unsatisfactory.

6. The Committee are not responsible for ensuring that the terms of any agreement submitted to them are fair as between the parties. Their duty in this connection is simply to express an opinion when they are satisfied that the transaction is free from unlawful sale of goodwill. Indirectly, however, the question of "fairness" may arise. Thus, in terms of the Statute, the unlawful sale of goodwill may take various forms. "Sale" is not limited to the simple passing of money. The offence may be constituted by the giving of consideration in other ways, e.g., by the performance of services. In considering whether a transaction is or is not obnoxious to the Statute, it is necessary to ascertain whether there is a goodwill which it is unlawful to sell. It is necessary to consider whether the agreement contemplates that this goodwill or some part of it may pass from one party to another. It is necessary to consider what consideration is to be given by the party to whom the goodwill may pass; and for what that consideration is being given. Where such consideration is to be given by way of services rendered, and these services do not appear to be compensated by an adequate return (other than the benefit of the goodwill), the inference may arise that the services are to be given partly at least, in consideration for some share of the goodwill.

7. In determining whether the returns provided by an agreement for services to be rendered are adeqaute (without any element of sale of goodwill) it may be legitimate to start from the hasis that equal services *prima facie* deserve equal returns, but in practice the application of this principle must depend on the circumstances of the case. A provision that each partner is to devote full time to the partnership does not necessarily mean that each is making an equal contribution to the earning

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of the partnership profits. Moreover, such factors as age, experience and ability may justly be taken into account. It seems reasonable that where a senior practitioner assumes a junior into partnership, the superior experience, prestige, responsibility and other qualities of the senior may justify an attribution to him of a major share of the partnership returns. But it is to be expected that this "seniority" value should diminish (relatively) as the junior gains in experience and usefulness, and undertakes increasing responsibility. "Seniority value" may justify an inequality of shares of profit in the initial years of a partnership; but there should be a progression towards equality. If the senior partner is an elderly man, a more rapid approach to parity may be appropriate, and it may even be appropriate for provision to be made for the junior receiving a higher share than the senior. Infirmity or ill-health is a factor also to be taken into account. If the assuming partner is little if at all senior to the partner being assumed, no more than a nominal disparity of the shares of profits may be justified, even in the initial stages. While each case must be considered on its merits, any apparently substantial over-assessment of "seniority value" may well be tantamount to the sale of goodwill, unless it can be shown to be justified on other and specific grounds.

8. If it is the intention of parties that there should be a progression towards parity or near-parity, this should be provided for expressly. If this is not expressly provided for, provision should be made for periodical review. Such review may be operated by way of arbitration: and if this is the intention, it should be made clear that the arbitration clause is not confined to a mere interpretation of the agreement, but authorises the arbiter to make such a review.

9. Some of the partnership agreements submitted to the Committee include restrictive clauses. In the past, such clauses were usually framed so as to restrain an outgoing partner from competing during a specified period from the date of dissolution. In agreements entered into before the appointed day, this was no doubt perfectly proper; for it was then legitimate for parties to make their own bargain on terms which allowed the possessor of an established goodwill to sell it, or to buy it back at the termination of a partnership, and to protect it as a valuable asset after the dissolution. It may be questioned how far such provisions are justified in agreements entered into after the appointed day. But where a restrictive covenant is provided for, it undoubtedly constitutes one of the elements entering into the consideration given and received. Accordingly, in assessing whether the consideration given and received under an agreement is fairly equated to the returns (and may therefore be assumed to be innocent of any element of sale of goodwill), it is important to ascertain what the effect of the restriction may be in all the circumstances in which it may operate. If a restrictive covenant is so framed that its operation may in any circumstances deprive a partner of a fair return for services rendered, this may give rise to the inference that the restriction is being accepted, in part at least, in consideration of his being admitted to a share of the goodwill. Particularly if such a restriction is framed so as to be operable against one partner only, and not all, the inference may be manifest that it represents an exploitation of goodwill tantamount to sale.

10. It may be contended that during the period when a newly-assumed junior partner is obtaining the benefit of introduction to established patients, it should be open to the senior to protect his legitimate interests by a clause which restrains the junior from unfairly attracting those patients to himself in the event of his choosing to sever the partnership. It is suggested, however, that such protection may be sufficiently assured by a clause designed to operate over a period starting, not from the date of dissolution of the partnership, but from the date of assumption of the junior partner concerned. It is felt that once the junior has reached the stage of substantial contribution to the work of the partnership, and a state of mutual confidence has been achieved, protection by such a clause is no longer necessary, and is not easily justifiable. Care should therefore be taken to ensure that any restrictive covenant is so framed that, taken by itself or in conjunction with other clauses, it is not inconsistent with the statutory prohibition of sale of goodwill.

11. The foregoing Memorandum has been drawn up as a general guide. *Mutatis mutandis* is may be applied to the case of multiple partnerships, or other forms of agreement. But each case falls to be decided on its merits, and in the light of its own particular circumstances.

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APPENDIX III

Initial Practice Allowances

(This Memorandum was issued by the Committee to Executive Councils.)

1. The Committee think it might be helpful to Executive Councils if they stated the main considerations which at present they take into account in determining whether or not a particular part of an Executive Council area should attract one or more Initial Practice Allowances. Most Executive Council areas are, of course, too large to be treated as a whole for this purpose; it is therefore the Committee's practice to break down these areas into appropriate districts, and consider each by itself.

2. The first consideration to which the Committee direct their attention is the average number of persons per doctor. But it is obvious that taken by itself this could be misleading. It is necessary to take account at the same time of such factors as type of practice, age of doctors, size and geography of district, total population, and distances to be travelled by doctors.

In any district where the average number of patients on doctors' lists is over 2,500 a new practice would normally be regarded as eligible for an Initial Practice Allowance unless the introduction of even one doctor would excessively reduce the average list. Where, however, the average list is under 2,500 but over 2,000 the question could only be determined after a careful scrutiny of the various factors mentioned above. Exceptionally a district with an average list of less than 2,000 might call for consideration on the same basis.

3. It is always open to any Executive Council, after reviewing the conditions prevailing in the different parts of their area, to recommend to the Scottish Medical Practices Committee that an Initial Practice Allowance should be made available for a particular district whether or not they have before them a definite application for such an Allowance from a practitioner. Any such recommendation would receive the careful consideration of the Committee who would inform the Council of their decision as soon as possible. The Council would then be in a position to inform any enquirer whether or not a new practice would carry an Initial Practice Allowance, it being clearly understood that any decision of the Committee approving such an allowance was conditional on no change of circumstances taking place subsequently.

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APPENDIX IV

VACANCIES DEALT WITH BY EXECUTIVE COUNCILS IN SCOTLAND IN EACH OF THE FIVE YEARS ENDED 30TH JUNE, 1958

Method of dealing with vacancy	Year ended					Total
	30th June, 1954	30th June, 1955	30th June, 1956	30th June, 1957	30th June, 1958	
Filled by introduction of new doctor after advertisement ...	26	18	25	13	30	112
Filled by introduction of new doctor without advertisement ...	4	2	3	1	1	11
Filled by introduction of new partner ...	13	7	7	9	16	52
Not filled (i) Patients transferred to list of other doctor in area* ...	29	30	32	32	45	168
(ii) Patients advised to select a new doctor for themselves ...	23	20	11	16	8	78
Total	95	77	78	71	100	421

* In most cases the doctor (or doctors) to whom the patients were transferred was an existing partner of the resigned or deceased doctor.

APPENDIX V

APPEALS BY UNSUCCESSFUL APPLICANTS FOR VACANCIES DEALT WITH BY SCOTTISH MEDICAL PRACTICES COMMITTEE IN EACH OF THE FIVE YEARS ENDED 30TH JUNE, 1958.

		Year ended					Total
		30th June, 1954	30th June, 1955	30th June, 1956	30th June, 1957	30th June, 1958	
Number of Appeals determined after Hearings.	A	2	1	—	1	1	5
	D	1	—	—	4	5	10
Number of Appeals determined summarily.	A	—	—	—	—	—	—
	D	8	3	7	7	1	26
Number of Appeals withdrawn before decision was reached... ...		2	1	2	—	—	5
Total ...		13	5	9	12	7	46

A = Allowed. D = Dismissed.

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APPENDIX VI

Table showing the number of applications for certificates in respect of partnership agreements made to the Scottish Medical Practices Committee under Section 36 (9) of the National Health Service (Scotland) Act, 1947, the results of these applications, and the total number of partnerships formed in Scotland in each of the five years ended 30th June, 1958.

Decision of Committee	Year ended					Total
	30th June, 1954	30th June, 1955	30th June, 1956	30th June, 1957	30th June, 1958	
Certificate granted immediately	10	5	10	11	4	40
Certificate granted after amendment made to the agreement ...	8	5	4	5	6	28
Certificate refused ...	4	1	7	2	3	17
Total Applications Made	22	11	21	18	13	85
Total Number of Partnerships Formed ...	95	71	84	68	75	393
Proportionof total number of partnerships in which applications for certificates were submitted	23%	16%	25%	26%	17%	22%

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Examination of Witnesses

DR. J. T. BALDWIN, *Chairman*
MR. A. I. MILLAR
MR. J. MCCALLUM, *Secretary*
MR. A. B. FAIRWEATHER, *Former Secretary*

on behalf of the Scottish Medical Practices Committee

Called and Examined

5195. *Chairman*: You will appreciate, I am sure, that as we have been sitting for a long time now and have a great deal of evidence, we may consider some of the ground covered in your memorandum to be outside our terms of reference, but there are certain particular matters on which you can help us.

We have allocated the job of preparing for this particular hearing to a sub-committe, of which Sir Hugh Watson has been acting as Chairman, so he will be asking you most of the questions. However, any of us may chip in and we want you to feel perfectly free to answer in turn. Who is to be the principal spokesman for the Scottish Medical Practices Committee?——(*Dr. Baldwin*): I am.

5196. Would you care to start, Dr. Baldwin, by telling us the terms of reference of the Committee, if there are any, as distinct from their duties? By whom are you appointed?——We are appointed by the Secretary of State.

5197. Direct?——In the National Health Service (Scotland) Act, 1947, paragraph 35 (2), it says: "With a view to securing that the number of medical practitioners undertaking to provide general medical services in the areas of different Executive Councils, or in different parts of those areas is adequate the Secretary of State shall constitute a Committee, to be called the Scottish Medical Practices Committee, for the purpose of considering and determining applications". It then gives details of the constitution.

5198. Is the Committee partly lay and partly medical?——Yes, Sir. The Chairman of the Committee is required to be a medical practitioner, and there are three medical practioner members, all of whom must be in active practice. The Chairman, himself, does not need to be, but always has been. There are also two lay members, one of whom is an advocate and the other, Mr. Millar here, is a layman who has a wide knowledge of National Health Service affairs.

5199. *Sir Hugh Watson*: So that you do not, in fact, have any terms of reference, except what is provided in the Act?——That is so.

5200. And the Act lays down the duties which you are to perform, which you set out in your memorandum under paragraphs 1 (*a*) to (*m*)?——Yes.—(*Mr. Millar*): The Act, itself, specifies one other duty which we have got to perform, and that is to give certificates for partnership agreements. All of our other functions are imposed on us by regulations made by the Secretary of State.

5201. In your paragraph 2 you say that you do not feel qualified to make any comments on the quality of applicants for vacancies. But you do have some contact with these applicants. As we understand it, you have to deal with people who appeal against the decision of the Executive Council in connection with an appointment to a vacancy. You have the last word, do you not?——(*Dr. Baldwin*): Yes.

5202. And, similarly, those who are entering a partnership by agreement with the other partners come under your scrutiny?——An application to join the medical list is received by us from every practitioner wishing to join the list, but we do not necessarily have any personal contact with these applicants; in fact, in the majority of cases we do not see them at all.

5203. So you would not know very much about them, really?——Not really.

5204. In your paragraph 2, you say that generally the doctor selected has had good experience both in hospital and in general practice. What is your Committee's view of the value of hospital experience in general practice?——

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If I may make a general statement, I would like the Commission to appreciate that I am only part-time Chairman of the Scottisb Medical Practices Committee. I have other functions in the National Health Service, and I may find myself speaking rather from the point of view of a practitioner. It is difficult for me sometimes to separate that.

5205. *Chairman*: That will still be of great help to us. I do not think we mind in what capacity you are speaking. ——We attach a considerable amount of value in general practice to hospital experience. We would regard it as necessary and, in any case, the Medical Act now requires a graduate to have a year's hospital experience after graduating before he becomes a registered practitioner. We feel that the probability is that he would be much better if he had even a little more hospital experience. On the other hand, we feel that he could have too much hospital experience for entering general practice. For example, if he continued in his hospital experience, it is more than likely that his experience would become channelled into a specialty, and if it were one of the less common specialties it might well be of little use to him in general practice; for example, neurosurgery, thoracic surgery, or something of that kind. On the other hand, if be bad an additional appointment in obstetrics it would be of the greatest possible value.

5206. *Sir Hugh Watson*: I think we have had exactly that expression of opinion elsewhere. So, generally speaking, your view would be that it would not be of advantage in general practice for a person to pursue a specialised line in hospital?——That is so.

5207. But if he could study further in hospital some particular line which would be of use to him in general practice, such as obstetrics, that would be a good thing? ——Yes.

5208. *Chairman*: What you actually mean in your paragraph 2, when you talk about having good experience both in hospital and general practice, may very well be just one year or 18 months as a House Officer?——Yes.

5209. *Sir Hugh Watson*: You are a member of an Executive Council?—— I am, Sir, yes.

5210. Would your experience as a member of an Executive Council lead you to suppose that Executive Councils undervalue hospital experience?——I do not think they do.

5211. We have had a lot of evidence to the fact that it is difficult to go from one branch of the profession to the other, except in the very initial stages. It is difficult for people to get from the hospital service into general practice and vice versa.——Yes.

5212. You accept that that is the position?——Yes I do, indeed, and further than that it is difficult, having once obtained a post in general practice, to obtain another one. It is difficult to move even from one medical practice to another medical practice, within the same branch of the service.

5213. Yes, that is another point. But we have had evidence that there is a certain rigidity, almost, as between the two branches of the profession.——Yes, that is so.

5214. Do you think that is a good thing?——I think it is too rigid.

5215. How would you suggest that that could be improved?——It is difficult to say. We have not given great thought to it, but I think one thing which would be of advantage would be if, for example, general practitioners had opportunities to take hospital appointments as clinical assistants, or whatever you care to call them, where they would have an opportunity of working with consultants, in order to obtain experience which would enable them to take additional qualifications.

5216. *Chairman*: We are, of course, very much on the remuneration point. Are there any features of remuneration that make it particularly difficult for anybody to pass from one branch to another, from general practice to hospital service, or vice versa?——As far as the present remuneration structure is concerned, you mean? There is no theoretical difficulty or theoretical reason why a general practitioner should not undertake an appointment outside general practice. He can still act as a general practitioner and can contract with the local Executive Council and take an appointment in the hospital service, assuming it is a part-time appointment. But I have no knowledge of the working in the opposite direction, as to how possible it is for a person employed in the hospital service to obtain general practice experience.

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5217. The point I was getting at was are the levels of remuneration at these sorts of ages in the two hranches of the profession near enough in halance for it not to he a great deterrent for somebody to move from one to the other?——I do not think I can give an authoritative opinion on that, Sir.

5218. *Sir Hugh Watson*: I am not quite sure what is the right place to bring in the next point, but prohahly this is as good a place as any. We have heen told ahout trainee assistants, but we have not heard very much about them, really. Can you tell us, in the first place, how the trainer doctor is chosen?——Yes, Sir. In Scotland the procedure is different from that which ohtains in England and Wales. In Scotland there is in each region of the National Health Service a Committee appointed to select trainer practitioners. In the South-Eastern Region, the region with which I am familiar, the Committee consists of a Chairman, who is a layman, and members who are general practitioners, appointed hy the Secretary of State but nominated hy the Local Medical Committees; also, representatives of the consultant service, whom I presume are also appointed hy the Secretary of State. They meet in this area twice every year to consider applications from practitioners to be appointed as trainers. There is a memorandum which lays down the criteria which the Committee use in considering whether the practitioner should he regarded as a trainer. These, I may say, are such that, broadly speaking, it is considered that if a practitioner has a practice of such a size that he is likely to be very husy, he is not considered to have the time to train an assistant. Therefore, a practitioner in an urhan area who has more than 2,500 patients, or in a rural area who has more than 2,000 patients, is regarded as having a practice which is too large to enahle him to devote time to the training of an assistant. The applications are made on a form which goes to the Secretary of the Committee. They are suhmitted to the Committee, and I can safely say that each applicant is known to several members of the Committee, personally. General practitioner representatives on the Committee as a rule know the applicants to a certain extent. We have valuahle help, also, from the consultants who are very well aware, as you know, of these practitioners' qualifications as practitioners, and as likely trainers. Does that help you, Sir?

Sir Hugh Watson: Yes, indeed. We did not know anything ahout that at all.

5219. *Mr. McIntosh*: And what is the practice in England and Wales?——I am open to correction on this, but I understand that in England and Wales the Committee is hasically the Local Medical Committee, and there are certain University representatives or consultant representatives, or something of that kind, hut the Local Medical Committee is the principal unit.

5220. But with the same criteria?——I do not know ahout that.

5221. *Chairman*: Do the same doctors normally go on heing trainers year after year?——They go on often for several years, hut it is the practice in the South-Eastern Region, which is the only one that I know ahout—hut I believe there is a similar practice in other regions—to consider that after a period of four or five years the trainer should have a rest from training; and in any case the practitioner is not appointed for several years in succession, if there are other suitable praotitioners who are availahle to act as trainers. It is generally regarded as desirahle that, after a period of at most five years, a practitioner should have at least one year break.

5222. Is it, in fact, a mark of being a rather good doctor to he chosen as a trainer?——Yes, Sir.

5223. *Sir Hugh Watson*: What induces a doctor to apply to be a trainer?——I do not know. It is very difficult to say that. I should think it is difficult to escape the view that he feels he may get a little help. It is almost certainly the case that he does not need help.

5224. Because he has only got at the most 2,500, or 2,000 in a rural area?——Yes. In the practice in which I am a partner, my senior partner is a trainer practitioner and has been for some years, and we have found it quite a stimulating thing for us to be trainer practitioners. We learn a tremendous lot from the trainee, and I understand that the trainees have been satisfied with their training and they tell us that they have learned from us, too. But the curious

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thing is that when our turn came to bc without a trainee we found we were, perhaps, a little less busy when he was not there, than when he had been there.

5225. *Chairman*: Is the trainee appointed to a practitioner, or to a partnership?——To an individual practitioner.

5226. And more often than not will it be a practitioner in a partnership or single-handed?——Speaking from memory, I should say about half and half.

5227. *Sir Hugh Watson*: Is the scheme largely taken advantage of?——In the South-Eastern Region there are always more applications to be trainers than there are training practitioners.

5228. I meant it the other way.—— You mean so far as the assistant is concemed?

5229. Yes.——No, not as much one would have thought. It is well known that it has been difficult to get a trainee over the past year or two, and I know that in some parts of the country it is more so than others.

5230. Do you think that the scheme is a good scheme?——I do, indeed.

5231. You think it is better than just turning a young doctor loose as an assistant?——It is difficult to say that. I think that the essential reason why the trainee scheme is a good scheme is that there is no doubt in my mind that the way an assistant in general practice starts his work—that is to say, the kind of practice that he finds himself in—is what will influence his way of practice during the rest of his professional life. I am sure that there is some reason for that statement, and, if that is the case, if he gets into a good practice to start with then he is likely to he a good doctor in the future. But there is no doubt that there are practices in which the kind of training is not all that could be desired.

5232. *Mrs. Baxter*: If a trainee assistant is taken on he stays there for one year?——Yes.

5233. If he enters as an assistant to a partnership, there is no necessity for him to leave at the end of the year, so he is likely to stay?——He can stay there as long as he is offered the post.

5234. So entering as a trainee assistant, does the young man get experience of at least two practices?——Yes. You mean that he has his year as a trainee, and thereafter he goes elsewhere?

5235. Yes, and thereafter would he go as an assistant, or would he he likely to get a partnership straight away?——It varies a great deal. Ordinarily, he would not get a partnership straight away—it is unusual for a doctor to go straight into partnership. It is customary for him to undertake a preliminary period of assistantship, even if it is not a very long one. On the other hand, I know some trainee assistants who, after their training year, have felt certain shortcomings, having been in practice; they feel they would prefer to take up a hospital appointment, and they have gone back to hospital appointments for six months or so, and have then again entered practice as an ordinary assistant.

5236. *Chairman*: Is there difficulty for someone who has just finished his job as a trainee assistant, in finding a full genuine assistantship?——There is some difficulty. The difficulty is not so great as it is sometimes made out to be. I think that the difficulty is very often due to the fact that an assistant wishes to restrict the area in which he practises. In my own practice we have had experience of that kind. An assistant, an able man, wished to practise within the Edinburgh area and he found some difficulty in getting a place that suited him. Another one, who was prepared to go anywhere, obtained a partnership in a very short time in the North of England in an industrial practice.

5237. *Sir Hugh Watson*: In your Appendix I we notice that, on the average of the five years given there, only about ten doctors have set up single-handed new practices. Would that be a large figure, do you think, or a small figure? ——I do not know whether I can say if it is a large or a small figure, Sir. I have no idea what sort of percentage of doctors, before the National Health Service, set up a new, single-handed practice, so I do not know whether the numhers are declining or not. I think the tendency will be for them to decline.—*Mr. Fairweather*: Single-handed practices have been declining, particularly since 1953, when the new arrangements about payment for partnerships were introduced.

5238. There are three ways of getting into general practice, as the Commission understand it. You can succeed to a

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practice vacancy, you can become an assistant, or you can put up your plate, which is the one we are talking about at the moment?——Yes.

5239. And we understand that the method which is normally used is for a doctor to become an assistant, and then become a partner?——*Dr. Baldwin*: Yes, indeed.

5240. In Scotland you do not have designated areas, as they have in England?——That is so.

5241. But the Executive Councils and the Medical Practices Committee know very well the areas which are very well doctored, and while they do not have these English classifications, in practice the thing works pretty much the same way, I suppose?——I think it does, in a way, except that if in Scotland we adopt the practice of English Committees, the areas which would be classified as closed areas would be very few.

5242. Having that in view, what do you think about this figure of 10 people who put up their plates?——There is a difference between an area which is adequately doctored, and one which is very much under-doctored. We prepared a table which indicated the success of practitioners setting up a single-handed practice with an Initial Practice Allowance. It was a very instructive table, and showed that, generally speaking, the only likelihood of a practitioner putting up his plate and meeting with success—that is to say, building up a practice within three years, in which he could earn his living—would be if he were in practice in a newly developing area, where new houses were going up and people were coming in. In an already developed area, where there were already practitioners practising in the area, his likelihood of practising by ethical means and attracting to him enough patients to make a living in that range of time was very remote. The average person is not prepared to change his or her doctor.

5243. *Chairman*: In the light of that, would you think that 10 new practices a year was not bad?——I would say it was not so bad. Mr. Fairweather has a graph, which he can show you.

5244. *Sir Hugh Watson*: For the record, Mr. Fairweather has produced a graph* which shows, with a dotted line the number of applications from doctors to practise in partnership.——*Mr. Fairweather*: And with an unbroken line it shows the number of applications to practise single-handed. You will see how the partnerships shot up in 1953 at the time of the new award.

5245. The applications for single-handed practices never rose more than about 10 in a year?——Yes, that is so.

5246. In 1953 the applications to practise in partnerships rose to very nearly 60; in general they appear to be running at about 25 to 30?——Yes. Actually, these are not yearly but quarterly intervals. That point of 60 you mentioned was in respect of one quarter.

5247. It goes to a peak after the alteration that you have been talking about?——Yes.

5248. *Chairman*: It does seem that in the same quarter as you had this great peak of partnership applications, you had a peak of single-handed ones. The tail-off has been to about 2 or 3 compared to 15 to 20, of course?——Yes.

5249. *Sir Hugh Watson*: You referred just now, Dr. Baldwin, to the Initial Practice Allowances. Do you think these allowances are achieving the purpose for which they were intended?——*Dr. Baldwin*: This is a personal opinion, but I think that they do so only in those cases where a practitioner enters a newly-developing area, in which there are a large number of patients. I should say that, in order to succeed in its purpose, the Initial Practice Allowance in an area where there were not a lot of new patients coming in would require to be tapered off much more slowly.

5250. In other words, it would take the practitioner much more than three years to establish himself?——Yes, and the third year's allowance is very meagre if he is not attracting patients.

5251. Applications for these allowances are made to your Committee?——After having been to the Executive Council who, with the Local Medical Committee, consider them and make recommendations to us.

5252. Can you tell us the criteria which govern the consideration of these applications?——Yes, Sir. Very largely, the criteria which we use in considering

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whether an area is in need of an additional practitioner are in the document which we have submitted to you, but there are other factors, too. We consider each case on its merits. We receive from the Executive Council the names of practitioners practising in the area—if there are any, and there usually are—and the numbers of patients on their lists and their ages. There are also other considerations which we sometimes take into account, such as special conditions relative to the particular district. It may well be that it is considered desirable that a particular practice should remain as an entity, in which case the Initial Practice Allowance may be given to encourage a practitioner to start there. There might be possibly the case of a practice where it was felt desirable that a woman's practice should be maintained in an area, and that might be an additional reason. These are special reasons, but you will notice that we consider certain figures and numbers of patients.

5253. Are many of these applications refused in practice?——No, not many are refused. I think that the Committee will sometimes wonder whether they will result in a practitioner being able to estahlish himself, but as a general rule applications are not refused.

5254. Turning to another subject, we have had some suggestion, without anything very definite being put before us, that in some quarters there is a tendency to exploit assistants. Naturally, that evidence has come mostly from the assistant side of the profession. You have sometimes refused permission for the employment of an assistant?——Very, very rarely indeed, Sir. It has not been done since I became Chairman of the Committee.

5255. On what grounds would you consider that a Committee would be liable to reject such applications?——Perhaps Mr. Millar, who has had some further experience, could tell us that. He has been a member of the Committee longer than I have.—*Mr. Millar*: We have had very few of these cases, but one curious aspect which one finds is that the reason an Executive Council has refused consent to the employment of an assistant is often that they think that the practitioner should have another partner rather than an assistant, so they try to exercise pressure on him to take in a partner. Of course, this is rather a difficult situation, because we have no power to force a doctor to take a partner, and if he is determined not to take a partner and wants an assistant and nothing else, then if he is refused the assistant he is left with no assistance at all, and that is not so good for the patients. So it is sometimes difficult to know how to handle cases. One has to take the interests of the patient into account, and if one is going to be swayed by that aspect, one gives consent to the employment of an assistant as being better than nothing.

5256. Yes, but what you are saying very nearly comes to the fact that there are quite a number of cases in which the Executive Council think that the doctor should not, in fact, have an assistant; he ought to have a full partner.——That is so.

5257. Which would almost confirm the view that assistants, if not exploited, are made use of in circumstances where they should not be made use of.——Yes, I should think that is a correct statement of the Executive Council's feelings in the matter.

5258. In all the circumstances, does the Committe think that assistants should be employed, and that it is permissible to employ or reasonable to employ assistants?——*Dr. Baldwin*: My personal view in this matter is that if a doctor thinks he should employ an assistant, and is prepared to pay his salary out of his own pocket, there is no reason why we should interfere.

5259. There is, of course, no scale of salary laid down for an assistant?——That is so.

5260. There is a scale for a trainee assistant, but there is no scale for an ordinary assistant?——Yes.

5261. Do you think that circumstances as they are give any reason to suppose that there ought to be such a scale laid down, or does the market find its own level?——I think that, generally speaking, the market finds its own level. I think there is no doubt that the scale laid down for a trainee assistant has proved to be some sort of a guide. It is most unusual for an ordinary assistant to be remunerated except at a little higher level than the trainee assistant. But, generally speaking, I think that the assistant's salary is probably fair, at least in the initial stages.

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